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A publication of the *Mahatma Gandhi Center for Global Nonviolence* at James Madison University

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The *International Journal on Responsibility* (*IJR*) is an international, peer-reviewed, interdisciplinary forum for theoretical, practical, and methodological explorations into the various and complex issues of responsibility, animated by the question, “Who or what is responsible to do what for whom?” *IJR* is a broad-ranging journal that incorporates insights from the full range of academic and practical inquiry from the humanities and the social and natural sciences related to addressing the diverse aspects of responsibility.

IJR publishes papers, comments, and other writings on responsibility. The contents examine intellectual, practical, policy and ethical issues relating to responsibility. In addition, the journal encourages research and reporting on ways in which responsibility relates to issues ranging from individual to broad public concern, past, present, and future. Topics in *IJR* include the use of responsibility in academic and nonacademic settings; structural and ideological dimensions affecting the development of new perspectives on the topic of responsibility; the ethics of research, teaching, and practice of responsibility; the application of a focus on responsibility in practical problems; the historical and interdisciplinary roots of responsibility; and the contributions of a focus on responsibility for interpersonal, policy and public issues.

The journal accepts submissions on the full range of topics related to responsibility as well as special editions dedicated to one topic. Manuscript submission guidelines for authors appear on the final page of each issue.

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Introductory Remarks on the *IJR* Special Issue, *Responsibility in Counselor Training and Practice*

Chad Luke & Fred Redekop

We are excited to introduce a special issue of the *International Journal on Responsibility*. Responsibility in counseling and psychotherapy encompasses a wide variety of topics and issues, ranging from specific situations with specific clients to the broadest discussions of ethical duties owed by counselors and psychotherapists to society. As counselors and counselor educators, we (Chad Luke and Fred Redekop) focus this special issue on the twin topics of counselor training and clinical practice. As the articles in this special issue demonstrate, the question of responsibility is found at the core of counseling ethics. Counselors and educators of counselors continually ask themselves: What responsibility do I have to ensure that I am doing good for my client? Am I taking care to respect their autonomy? Am I as a counselor educator ensuring that my students recognize that they will hold professional responsibility toward their future clients and am I helping them to grow in this sense of responsibility?

We are happy that the articles cover a range of roles in the profession from practice to training. Practice includes topics such as soliciting client feedback on therapy, coercion in therapeutic encounters, and ending the therapeutic relationship well. These in-practice roles and tasks carry weighty responsibility for counselors. Likewise, the dimension of training of counselors may carry additional weight of responsibility, as training precedes practice. Three articles address a range of roles and responsibilities in preparing counselors-in-training (CITs) to enact their duty. These include actively engaging CITs in ways that illuminate their specific and general responsibilities in the profession, developing majority-status CITs' understanding of their broader responsibility to society in becoming allies for underrepresented and marginalized groups, and identifying those students who are unsuitable to enter the profession and taking steps to remediate or divert from the profession. We briefly summarize the contributions, in preparation for a reading of the articles themselves.

Zach Budesá, in *Feedback-Informed-Treatment: A Deliberate Approach to Responsible Practice*, tackles one of the most necessary developments in clinical practice: the need to solicit feedback from clients, analyze this feedback, and use the results of the analysis to monitor client progress and, if necessary, modify treatment to improve clinical outcomes for clients. Budesá uses the well-established framework of deliberate practice (Ericsson, 2004; 2015; Ericsson, Krampe, & Tesch-Römer, 1993; Ericsson & Lehman, 1996) to organize his discussion of feedback-informed treatment (FIT) in counseling. FIT follows the principles of deliberate practice, and Budesá marshals a significant amount of research as he argues for much greater attention and more strenuous efforts to systematically gather useful data using validated measures in clinical settings. He places this within the larger context of clinical outcome research that has increasingly emphasized the importance of paying close attention to client perspectives and opinions in order to increase the likelihood of positive treatment outcomes.

The authors of *When People Lose Autonomy: The Case for Coercion and the Moral Responsibility Crisis Counselors Have to Society*, Nathan Strickland, Chad Luke, and Fred Redekop, address a topic of some controversy, that of coercion in mental health crisis management. In their article, they explore the concept of coercion in mental health crises through the use of vignettes, and suggest that it is best understood on a continuum: crisis clinicians, when confronted with an individual in acute distress who appears at risk for harm to self or other, typically attempt first to hold a relatively unpressured dialogue with an individual in order to arrive at a wise decision, what the authors term conversing. Convincing is the next step up, and may include not only appeals to logic and an individual's sense of what is in their best interest, but also a presentation of what might occur if the crisis clinician and the individual cannot come to a mutual decision, e.g., involuntary commitment. Compelling occurs when the crisis clinician judges that the individual is unable to rationally decide what is in their best interest and presents an

acute risk of harm to self or other and decides that involuntary commitment is warranted. Throughout, the authors describe the interdisciplinary efforts of crisis management workers, including allied professions such as counselors and social workers, along with law enforcement, and compare and contrast professional ethics that bear on crisis management. The authors also address important critiques of mental health crisis management, in particular the critiques of Szasz (1960;1974) and Foucault (1965;1977), which challenge the field to justify coercive actions taken to limit the freedom of individuals. They suggest that crisis clinicians, faced with difficult decisions under ambiguous circumstances and attempting to reconcile often conflicting ethical imperatives, themselves experience moral distress and burnout. Thus, further discussion is needed for both the ethical implications of coercive practices on individuals in crisis as well as training and support for mental health crisis workers.

In their article, *Therapeutic termination: Translating clinical responsibility into ethically-informed practice*, authors Christina M. Schnyders and Kristin Bruns describe the responsibility counselors have to their clients to terminate the therapeutic relationship according the ethical guidelines and principles established by the profession. They explore termination by type in order to provide a richer understanding of the decisions that are made to transition clinical relationships. The case of “Malik” is used to demonstrate the varied considerations that counselors are responsible to engage in as they usher clients through these transitions. For many, if not most clients, this will be the first relationship that ends in a healthy way, rather than abruptly or painfully. In termination, counselors provide clients with an exceptional experience to their relational history, and invite them to approach subsequent relationships using the counseling relationship as a model.

The seeds of termination—the profession’s term for ending the formal therapeutic relationship between client and counseling—are sown at the very first meeting through a process known as informed consent. The informed consent document and process ensures that clients enter into the clinical relationship with full knowledge of the boundaries therein, among them, the time-limited nature of the work. In many ways, termination may be more accurately thought of as convocation, where, rather than merely being the ending of something, it is also the beginning, or launching out into something new.

The Development of Professional Responsibility in Counselor Training, written by Ryan Bowers and Helen Hamlet, identify a crucial transition that must take place in any counselor training experience: helping the counselor-in-training (CIT) to develop an ever-increasing sense of personal responsibility toward clients in field experience and in their future work as counselors. As Bowers and Hamlet aptly describe, the CIT begins with a passive view, locating therapeutic responsibility with instructors, and later, with site supervisors. The authors show how development of responsibility can be fostered by training programs, and use data from a survey to suggest that the CIT experiences an acute sense of responsibility as a result of program activities that may help them anticipate what it will be like to work with actual clients and through the clinical field experiences of practicum and internships. Bowers and Hamlet help counselor educators to be wary of overprotecting and stunting the growth of professional responsibility in their students. Counselor educators and clinical supervisors do assume burdens of responsibility for their students and supervisees, but much as a parent must help a child to gain life skills to assume increasing responsibility for their life, so too must counselor educators and supervisors take advantage of opportunities provided by academic and clinical training to foster a visceral awareness in the CIT of their ethical responsibilities toward clients and future clients.

Allyship: The Responsibility of White Individuals in Addressing Racism and Discrimination, written by Amanda M. Evans, Brittany Williams, Renée Staton, Darius Green, and Charles Shepard, presents a foundational component of counselor responsibility, which is to promote access to success for those living in the margins of society. White privilege comes with White responsibility to use that privilege to elevate the less privileged. Evans et al., discuss results of a qualitative exploration of perceptions of White members of the counseling community and self-perception of allyship. The authors introduce

readers to a qualitative research method referred to as Interpretive Phenomenological Analysis, as described in Smith (1996) and Smith, Jarman, and Osborne (1999). This method seeks to highlight participants' voices by honoring their lived experience of a particular topic (phenomenology). The approach is interpretive as it recognizes and even harnesses the researcher's own conceptualizations of the topic in order to better highlight the participant's perspective (Smith et al., 1996). Their analysis of 11 participants identified several facets of ally experience. Participants described witnessing of *overt acts of racism*. This is important because it requires that would-be allies be attuned to opportunities for allyship through observation. Participants identified opportunities for *addressing racism* when observing these racist events through intervention in the moment and education of those in their sphere of influence, namely counseling students. The results highlight the need for allies willing to take action through attention and intervention, particularly through the training of counselors.

Gatekeeping: A Counselor Educator's Commitment to the Counseling Profession and Community, written by Patricia Kimball, Lucy Phillips, Krista Kirk, & John Harrichand, offers a look at how the counseling community accepts responsibility for protecting the well-being of the public through a process known as gatekeeping. In essence, entry into the professional counseling community is managed by so-called gatekeepers, those whose role it is to assess potential entrants' knowledge, skills, and dispositions, prior to permitting entry into the field. There are two separate gates, the first kept by faculty in graduate counselor training programs, and the second kept by community-based clinical supervisors who approve a CIT's clinical hours toward professional license. Together, these two groups of individuals take steps to remediate students and supervisees who fall short of the high standards of the profession, and for those unable to demonstrate sufficient development, close the metaphorical gate. Kimball and her colleagues discourse on three core areas of assessment—knowledge, skills, and dispositions—which, based on the work of Ametrano (2014), serve to buffer the public from counselors lacking substantially in these areas. Of perhaps greatest interest to a broader community, the authors describe models of gatekeeping that systematically assess and remediate struggling CITs. These processes, and perhaps in particular, the model applied to the case of “Tanya,” offer assurance to consumers of counseling services that the field is working on their behalf to ensure that counselors receive adequate training and meet appropriate developmental milestones before being allowed accessed to loved ones.

We have immensely enjoyed the process of putting together this special issue and trust that you will find the discussion of responsibility in counselor practice and training to be stimulating and rewarding.

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**When People Lose Autonomy:
The Case for Coercion and the Moral Responsibility Crisis Clinicians Have
to Society**

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Abstract

The present article explores the responsibility of mental health crisis management clinicians around the world in the context of ethical practice. Concepts of suicide, autonomy, coercion, and civil commitment are defined through the lens of crisis intervention. Historical background and development of community-based crisis management in the United States, mental health crisis assessments, interdisciplinary crisis ethics, and a continuum of coercion in crisis intervention are discussed. The authors then lay out three clinical crisis case vignettes to demonstrate three levels of risk to safety and the appropriate implementation of the three levels of the continuum of coercion. Finally, a discussion follows on the interplay of professional ethics in the crisis vignettes, the academic debate on the use of coercion, as well as moral distress and clinician burnout. We posit that crisis clinicians, like law enforcement and other professional entities involved in mental health crisis management, bear the social responsibility of making difficult and morally ambiguous decisions for individuals who have lost their autonomy to a mental health disorder.

Keywords: mental health crisis management, civil commitment, autonomy, coercion, ethics, moral distress.

When People Lose Autonomy:

The Case for Coercion and the Moral Responsibility Crisis Clinicians Have to Society

Starting in the 1960s, *community mental health* emerged as a way to define mental health service provision in the United States and around the world. Baker and Schulberg (1967), in an early attempt to operationalize this ideology, suggested that the growing community mental health care movement represented a concern for individuals' psychological and economic well-being, employed a sense of intimacy with modern communication techniques, and controlled the social environment in a way that served society's best interests. In examining the extant literature, they found five principles governing the new movement: Mental health workers extended their focus beyond the identified individual to the entire population; workers concentrated on prevention rather than simply reacting to mental disorder in a population; workers downplayed individual pathology and instead helped individuals adjust to social life; mental health workers advocated for comprehensive and integrated continuity of care, so that an individual can be helped to move and navigate the network of services provided; and mental health workers liaised with other service providers and served as catalysts for total community involvement in the individual's life.

While these principles continue to define contemporary community mental health, the world has changed greatly since the 1960s with the realization of global interdependence, the evolution of technology, and the rise of multiculturalism, and so the concept of community mental health has been added to and redefined. There have been updates such as *global-community psychology* that is "based on multicultural, multidisciplinary, multisectoral, and multinational foundations that are global in interest, scope, relevance, and applicability" (Marsella, 1998, p. 1282) and *public mental health* that deals with "mental health promotion, prevention of mental disorders and suicide, reducing mental health inequalities, and governance and organization of mental health service provision" (Wahlbeck, 2015, p. 36). Community mental health, concerned with basic principles of nuanced and contextual care for individuals and informed by expansive updates, is the minimally acceptable standard for population-level mental health treatment in the United States and around the world (Wahlbeck, 2015).

Community mental health encompasses a multitude of psychological services, including the crucial component of multidisciplinary mental health crisis management. One group of professionals who intervene for crisis management for the best interest of individuals and society is community-based crisis clinicians. The emphasis on "community" is an important one, demonstrating the interdisciplinary and multi-faceted nature of crisis work, as it involves physicians, social workers, counselors, nurses, law enforcement officers, emergency medical service providers, and service recipients' families.

The work undertaken by the interdisciplinary team of crisis workers is an essential one. The basic productivity and wellness of society is greatly impacted by mental health crises, since people who suffer from untreated acute and persistent mental health disorders often find themselves out of work and otherwise unable to contribute to society (Jenkins & Minoletti, 2013). "Health in All Policies," a political push at the world level, for instance, has gained momentum, stressing that mental health policies are not isolated to the realm of mental health professionals, but rather pertain to general governance as mental health crises can constitute a threat to the health of society and must be addressed in policy-making (McQueen, Wismar, Lin, Jones, & Davies, 2012). For example, suicide and suicide attempts—common mental health crises dealt with by community-based crisis clinicians—cost the United States alone \$93.5 billion in 2013 (Shepard, Gurewich, Lwin, Reed Jr., & Silverman, 2016). This figure, taken in tandem with the rising rate of suicide and suicide attempts worldwide over the last 50 years—including the staggering figure of 800,000 yearly deaths by suicide around the world (World Health Organization [WHO], 2014)—indicates the need for crisis intervention around the world. In order to understand the role of crisis intervention, it is first important to agree upon common terms and their usage throughout this article, which are described next.

Terminology.

Suicide.

Within the context of this article, suicide comprises definitions of the term itself and of suicidal behaviors, as both constitute serious risk to mental wellness. WHO (2014) defines suicide as, “the act of deliberately killing oneself” (p. 12), while suicidal behaviors is a more encompassing term that includes thoughts of suicide, making plans for suicide, and attempting suicide, and suicide itself.

Autonomy.

Autonomy “is essential to the full functioning and mental health of individuals and optimal functioning of organizations and cultures” (Ryan & Deci, 2006, p.1559) and has been defined as “the ability of an individual to be his or her own person, to make his/her own choices on the basis of his/her own motivations, without manipulation by external forces” (WHO, p.28, 2015). In healthcare, practitioners give service recipients room to exercise autonomy by properly informing them of treatments/services and giving them the decision to accept or decline such treatments/services, which follows the doctrine of informed consent (Faden & Beauchamp, 1986). Another matter, then, arises of an individual’s ability or capacity to make informed and responsible decisions. Decision-making capacity through the lens of “external rationality,” or simply “the ability to make rational decisions” (Charland, 2015, para. 28) plays an important role in assessing autonomy within the crisis care continuum utilized in this article. We take the external rationality approach to decision-making capacity, rather than internal rationality, because in crisis situations individuals may operate with impaired or disordered internal rationality due to distorted, delusional, or otherwise disordered thought processes. Following this logic, an individual with a disordered thought process who is unwilling or unable to make responsible decisions to seek treatment has lost their autonomy to mental disorder.

Coercion.

A simple definition of coercion is the act of an agent using a technique or method “to get other agents to do or not do something” (Anderson, 2017, para. 1), which can be seen as infringing on an individual’s freedom by constraining choices. A common coercive technique used in crisis work is to utilize a threat of involuntary treatment to encourage the service recipient to accept a less restrictive treatment or service. Wertheimer (2014) argues that a threat is used to warn the recipient that he or she will be worse off if he or she does not comply, especially when the coercer proposes that he or she will violate the recipient’s rights. In the context of crisis work, crisis specialists often act as coercers in efforts to get treatment for service recipients, and at times employs a threat that generally follows an “if-then” formula. For example, a crisis specialist may say to an individual, “If you do not agree to voluntary treatment, then you will be forced to go to a psychiatric hospital for treatment.”

Continuum of Coercion.

Inspired by Wertheimer (2014), we have created a “continuum of coercion”: Conversing (light use of coercion limited to persuasion); Convincing (moderate use of coercion including threats); and Compelling (heavy use of coercion including civil commitment and involuntary hospitalization). This heuristic will be used throughout our article, in particular in discussing mental health crisis vignettes.

Commitment and involuntary admission/hospitalization.

A simple but operational definition of commitment is as follows: “the imposition of mental hospitalization over the expressed wishes of a patient” (Monahan et al., 1995, p. 249). Conditions for commitment are dictated regionally by legislation which establishes criteria, typically involving

“dangerousness,” or risk of harm, to self and others (Wynn, 2018; Testa & West, 2010). Internationally, criteria for involuntary admission varies widely, and there is no established universal standard (Zhang, Mellsop, Brink, & Wang, 2015), due in part to differences in language and legislation (Wynn, 2018). The above definition highlights the coercive nature of commitment, as it directly infringes on the notion of service recipient autonomy in favor of securing treatment/services to promote wellness in accordance with beneficence. This conflict of ethical values creates an ethical challenge which makes it difficult for a clinician to discern the best way to proceed (Hem, Gjerberg, Husum, & Pederson, 2018). Beyond ethical concerns over the use of commitment and involuntary treatment, the issue of efficacy is also noteworthy. Some research indicates that compulsory psychiatric treatment is overall ineffective (Strauss et al., 2013), though such findings are not replicated consistently (O’Donoghue et al., 2015) and research on service recipients’ feelings and perceptions on compulsory treatment provides mixed results (Lorem, Hem, & Molewijk, 2014). The use of coercion and commitment in crisis management is a source of conflicting views and ethical debate.

Recent Historical Context

In the years since deinstitutionalization in the United States and around the world, the role of mental health crisis intervention took on greater importance because individuals who had previously been institutionalized because of acute and persistent mental illness were afforded the opportunity to lead their lives in community settings (Chow & Priebe, 2013; WHO, 2013; Liu et al., 2011; Priebe et al., 2005), though this has proven difficult in developing and low-income countries (Kohrt et al., 2015; Luitel et al., 2015; Thornicroft et al., 2010; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; WHO, 2008). This change began to take shape in the United States with the creation of the first successful anti-psychotic drug, Thorazine, the establishment of Medicare and Medicaid in 1960, President Kennedy signing the Community Mental Health Centers Act in 1963, and the standard-setting institution of commitment criteria involving “dangerousness” in Washington, D.C., in 1964 (Testa & West, 2010). These developments were further bolstered by the short-lived Mental Health Systems Act of 1980 signed by President Carter, which allocated grant funding to community mental health centers (Grob, 2005). Due in part to political differences, the Omnibus Budget Reconciliation Act of 1981 signed by President Ronald Reagan repealed the majority of the Mental Health Systems Act of 1980 with the notable exception of section 501, otherwise known as the Patient’s Bill of Rights. This Bill of Rights states that service recipients must receive treatments which are “the most supportive of such person’s personal liberty” while also authorizing action to “restrict such liberty only to the extent necessary [and] consistent with such person’s treatment needs” (Mental Health Systems Act of 1980, §9501). These statements coupled together constitute the fundamental difficulty in crisis work: determining how safe an individual is or can be and what treatment most effectively addresses his or her needs. Crisis clinicians make this kind of clinical determination through assessment of risk and needs.

Civil commitment in the United States, otherwise known as involuntary hospitalization, places a temporary legal hold on an individual who has demonstrated, through psychological assessment, that he or she requires immediate psychiatric care due to imminent threat of harm to self and/or others (Testa & West, 2010). The United States is one of a number of nations that practices involuntary commitment, including the United Kingdom and other countries in Europe (Chow & Priebe, 2013). Assessment of adults in crisis takes into account several factors influencing the in-crisis individual’s mental status including, but not limited to, relational stressors with family, friends, and significant others; logistical or everyday stressors involving finances, legal concerns, and discrimination/stigma; and psychological stressors such as traumatic events, substance abuse, psychosis, mental health diagnoses, and suicidal/homicidal ideations. When individuals demonstrate low or minimal danger to self/others they can, with the appropriate social supports in place, choose whether or not to seek voluntary treatment on their terms. Through community mental health centers, clients can receive voluntary inpatient and outpatient treatment to ensure wellbeing and, ideally, individuals in crisis can autonomously make decisions that move them toward wellness such as seeking treatment; however, many individuals in crisis are unable or unwilling to make such decisions (Testa & West, 2010) and require more than what

even the most well-intended therapeutic interventions like Psychological First Aid (Snider, Ommeren, & Schafer, 2011) can offer. It is when in-crisis individuals demonstrate moderate-to-high risk and unwillingness to seek treatment voluntarily that clinicians employ coercion and civil commitment.

Ethics of Coercion

Because mental health crisis intervention is by nature an interdisciplinary treatment (Balfour, Tanner, Jurica, Rhoads, & Carson, 2016; Murphy, Irving, Adams, & Driver, 2012), so too are the ethics. These respective ethical codes contain significant overlap, but they also demonstrate subtle yet noteworthy differences as well.

Consider first the mental health professionals who work as crisis intervention clinicians, primarily counselors and social workers. While the American Counseling Association [ACA] Code of Ethics (2014) and the National Association of Social Workers [NASW] Code of Ethics (2017) bear a superficial resemblance to each other with shared values of autonomy, justice, and integrity, the language and structure used to outline key ethical principles raises an issue of hierarchy or priority. For instance, both documents describe the importance of maintaining service recipient autonomy; however, autonomy sits atop the list of the ACA Code of Ethics and is mentioned in the NASW Code of Ethics in the third guiding ethical value. Further, ACA states autonomy as, “the right to control the direction of one’s life,” while NASW describes it as, “clients’ socially responsible self-determination.” The distinction between these two descriptions of autonomy is critical in crisis work, particularly in NASW’s use of “socially responsible self-determination” whereas ACA makes no mention of social responsibility. This suggests that self-determination is legitimate if and only if it is socially responsible, that one’s freedom to choose one’s own course of action is acceptable as long as it is responsible to the rights of others.

Medical professionals such as physicians and nurses, who follow their own ethical codes and principles, also play a critical role in many mental health crises. We consolidate various medical practice ethics under the umbrella of biomedical ethics as outlined by Beauchamp and Childress (2001). Beauchamp and Childress (2001) state that biomedical ethics rest on the four pillars of beneficence, non-maleficence, autonomy, and justice. The similarity to the ACA Code of Ethics is readily apparent, though ACA lists autonomy first while Beauchamp and Childress list it third.

Further similarities and distinctions can be made among the ethical codes, as seen in Table 1, below.

Table 1. Crisis Provider Codes of Ethics

ACA Code of Ethics	NASW Code of Ethics	Biomedical ethics
<i>Autonomy</i> : fostering the right to control the direction of one’s life	<i>Dignity and Worth of the Person</i> : respect the inherent dignity and worth of the person	<i>Autonomy</i> : ensure that patients have the right to choose, as well as the right to accept or decline information or treatment
<i>Non-maleficence</i> : avoiding actions that cause harm	<i>Importance of Human Relationships</i> : recognize the central importance of human relationships	<i>Non-maleficence</i> : do no harm
<i>Beneficence</i> : working for the good of the individual and	<i>Service</i> : to help people in need and to address social problems	<i>Beneficence</i> : do good

society by promoting mental health and well-being		
<i>Justice</i> : treating individuals equitably and fostering fairness and equality	<i>Social Justice</i> : challenge social injustice	<i>Justice</i> : distribute goods and service, including medical goods and services, fairly
<i>Fidelity</i> : honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in professional relationships	<i>Integrity</i> : behave in a trustworthy manner	
<i>Veracity</i> : dealing truthfully with individuals with whom counselors come into professional contact	<i>Competence</i> : practice within areas of competence and develop and enhance professional expertise	

We must also look at the professional ethics for law enforcement due to their involvement in crisis intervention; this article uses the International Association of Chiefs of Police [IACP] Law Enforcement Code of Ethics established in 1957 as a baseline. This Code of Ethics reads more like a mission statement than the aforementioned codes. In its first sentence the document expresses that ethical law enforcement will “safeguard lives and property,” “protect... the weak against oppression or intimidation and the peaceful against violence or disorder,” and “respect the constitutional rights of all to liberty, equality, and justice” (IACP, 1957, para. 2). The guiding ethical values may be presented differently than in the other codes of ethics, but the core principles of autonomy, beneficence, non-maleficence, and justice are clear in all. The IACP also includes a statement on social and public responsibility which bears mentioning: “I recognize the badge of my office as a symbol of public faith, and I accept it as a public trust to be held so long as I am true to the ethics” (para. 5). Other ethical codes discuss social responsibility, but the IACP imbues the badge—an object prevalent in all professional roles in crisis response—with significance, which offers a concrete vehicle of responsibility that most of the professionals who work together in crisis management share.

In sum, the ethical codes which guide the various disciplines involved in crisis intervention overlap in key values, particularly in relation to autonomy, beneficence, non-maleficence, and justice. Conflicts emerge, though, in the disciplines' different interpretations of these key ethical principles, with particular attention paid to autonomy in light of coercive practices in crisis intervention such as civil commitment (Hotzy & Jaeger, 2016; Szmukler, 2015). To facilitate exploration of mental health crisis assessment, ethics, and the degrees of coercion used, consider the following cases.

Continuum of Coercion as Viewed in Three Vignettes

Phillip and Conversing

Case. Phillip, a 21 year-old college student who lives with his parents, presents at a community mental health walk-in center on a Tuesday afternoon due to suicidal ideations. Phillip reports that he has been depressed in the past but that this is his first time experiencing thoughts of killing himself. He denies having any suicidal plan, and he states he has not thought of a method. Phillip also denies thoughts of harming others or experiencing hallucinations. He explains that he has been especially stressed because he has been struggling in his schoolwork and he has been worried about what his parents will think of him if he does not get good grades, as they pay for his education at the local

university. He adds that he has been talking about his struggles with some of his friends, though he has found it difficult to discuss his current situation with his parents.

Phillip reports that he recently took some Adderall that a friend gave him because he thought it would help him perform better in his studies, denying any other substance use. He describes the following symptoms as present when not under the influence of Adderall and amplified when using the substance: excessive and uncontrollable worry his parents will stop paying for his college education, difficulty concentrating, frequent tension in his shoulders, nausea, as well as trouble getting and staying asleep. The crisis clinician discusses anxiety with Phillip and tells him that his current symptoms align with an anxiety disorder and that he may want to consider therapy to address the way he responds to anxiety, as it is troubling that his recent responses have included using Adderall as well as thoughts of suicide. Phillip says he does not want to stay at the mental health center's voluntary inpatient unit because he just wanted to talk with someone about his recent experience, he has multiple exams coming up at school, and he feels like he can remain safe at home with his parents. He initially does not want the crisis specialist to tell his parents about what has been going on, and the crisis clinician tells him that he cannot return home without someone responsible knowing the circumstances and agreeing to help. Phillip then consents for the crisis specialist to contact his parents to discuss Phillip's current mental status and establish a collaborative safety plan, and he agrees to return to the mental health center if his symptoms worsen.

Conversing. With Phillip's consent, the crisis specialist calls Phillip's parents, Shirley and Mark, on speaker phone with Phillip in the room. Shirley answers the phone and the crisis specialist tells her Phillip has come to the community mental health center for an evaluation due to his recently increasing anxiety and thoughts of suicide. Shirley expresses concern as this is the first she or Mark have heard of this, and she puts Mark on speaker as well. Phillip speaks up and tells his parents that he wanted to talk with a mental health professional first because he was afraid to tell them about his recent emotional state. He says he felt afraid to discuss it with them because he thought they would be disappointed in him.

Shirley tells Phillip that she and Mark want only for him to be happy and healthy and that they will help him however they can, and Mark echoes this sentiment. Mark tells Phillip that both sides of the family have struggled with anxiety issues in the past but they never talked about it because they did not want to worry Phillip. The crisis clinician then mentions that after talking about his recent mental state Phillip has decided that he feels safe to return home with his parents, with whom a crisis management plan would need to be established. Shirley and Mark agree that Phillip can be safe in their home and that they will assist however they can, and they agree to encourage Phillip to return to the community mental health center or call the regional crisis hotline if his anxiety and thoughts of suicide worsen. Shirley and Mark then say they will meet Phillip at the center to follow him home. The crisis clinician has decided that sending Phillip home with a crisis management plan is appropriate because while he is experiencing anxiety and thoughts of suicide, his decision-making and insight—which form the crucial components of autonomy—do not appear impaired, his parents agree that his decision-making is sound, and the parents agree to offer further social support to Phillip. The crisis specialist employed mild coercion in convincing Phillip to consent to informing his parents of the clinical situation.

Cases like Phillip's, in which service recipients maintain their autonomy, require trust between the clinician and service recipient, as well as an ability to coordinate with family members and friends to create a sound crisis management plan. The crisis clinician employed mild coercion—through conversing—in persuading Phillip to allow his parents to know about his recent mental status, and this was done to ensure that no harm would occur if Phillip went home (non-maleficence), Phillip and his family could begin openly talking about anxiety and ways to cope (beneficence), and that the crisis management process was equitable to all parties involved, in this case Phillip and his parents (justice).

Shawnda and Convincing

Case. Shawnda, a 36 year-old woman, was brought to an emergency room by law enforcement officers after one of her neighbors called the local dispatch reporting she heard Shawnda screaming and slamming objects against the wall of her apartment. Emergency department reports written by a nurse and a physician indicate that Shawnda agreed to be transported to the hospital by law enforcement officers so she could “get some help.” The reports also note that she states her reason for admission to the emergency room as, “My landlord put demons in the walls at my place and I was hoping to speak with a shaman or exorcist.” Shawnda had begun yelling loudly for a shaman or exorcist while in the ER, so the attending physician ordered that she be offered small doses of risperidone—an anti-psychotic drug—and lorazepam—an anxiety medication—in an attempt to calm her down. The physician states that she is familiar with Shawnda because of previous presentations to the ER under similar circumstances in the last four years, adding that the patient has a historical diagnosis of paranoid schizophrenia with religious preoccupation. Standard urine drug screening indicates no drug use prior to admission. ER admission paperwork lists no emergency contact.

During the crisis specialist’s assessment, Shawnda appears to have calmed down significantly and says with disappointment in her voice, “It happened again, huh?” She is able to relay that she believed there were demons in the walls of her apartment placed there by her landlord and this disturbed her greatly, as her faith plays an important role in her life. Shawnda adds that she began hitting the walls with her hands and shouting for the demons to leave her alone. She denies wanting to harm herself or others, stating that she could never harm anyone because of her spiritual beliefs. She further denies that she has seen the demons, but reports she has heard them say, “We will always be with you, no matter where you go. We will get you.” Shawnda tells the crisis specialist she has had similar experiences at multiple residences with different landlords and she fears that the demons will “get her,” adding that she simply wants to get rid of them. She tells the crisis specialist she has been sent to a state psychiatric hospital in the past and this was not helpful for her because she was afraid in that environment. She requests that she not have to stay at a psychiatric facility because she needs to find a new place to live, though she reports having no one to stay with in the interim.

Convincing. Following the conversation with Shawnda, the crisis specialist goes to discuss treatment options with the ER physician. The physician states that she thinks Shawnda is a good candidate for the local crisis stabilization unit, a voluntary inpatient treatment. The crisis specialist informs the physician that Shawnda does not want to stay at a psychiatric facility and thus more restrictive treatment through civil commitment may be needed. The physician asks that the crisis specialist first see if the crisis stabilization unit would accept Shawnda for admission and then try to convince her to stay there for a few days. The crisis specialist calls the crisis stabilization unit and relays the clinical situation to the unit’s charge nurse, who says Shawnda meets criteria but that she must also be willing to come to the unit.

With this information, the crisis specialist returns to talk with Shawnda again, informing her that the physician thinks she needs to stay at the crisis stabilization unit due to her psychotic symptoms. Shawnda reiterates that she does not want to stay at a psychiatric facility and adds, “I don’t need to stay anywhere either. I don’t want to hurt myself or anyone else; I just want to get rid of these demons!” The crisis clinician informs Shawnda that if she does not agree to voluntary inpatient treatment that then the clinically appropriate alternative, given the circumstances, is commitment and involuntary hospitalization because there is no one reliable with whom to establish a crisis management plan. The crisis specialist then gives Shawnda information about what the unit is like: there are therapy groups, medication consultation, and discharge planning services. Shawnda appears irritated and says, “I’m not happy about this, but I’ll go there if it keeps me out of a hospital.” The crisis clinician informs the ER physician of the decision and arranges transportation for Shawnda to the crisis stabilization unit. Psychosis clouds Shawnda’s insight to her current mental status but she remains able to make the responsible decision to get treatment, and so her autonomy is impaired but still partially intact.

The crisis clinician used moderate coercion in threatening Shawnda with civil commitment if she still could/would not decide to take part in voluntary inpatient treatment. In doing this, the crisis clinician gave Shawnda the opportunity to make a responsible decision (autonomy), ensured that she received treatment for her psychotic symptoms (beneficence), guaranteed that she would not inadvertently cause harm to self or others if she returned to her apartment (non-maleficence), and saw that the process maintained the liberties and well-being of Shawnda's neighbors and landlord (justice).

Frank and Compelling

Case. A crisis specialist is dispatched to the home of 48 year-old Frank after receiving a call from his father, who houses his son in a trailer on his rural property, reporting that Frank has threatened to rape his young niece and has also threatened to kill his father if he calls the police. Frank's father adds that "He's talking out of his head again and I don't know what to do. The cops don't do anything when I call them out here because he knows what to say." The father reports that he is unsure what Frank's diagnosis is but that he has been to the state hospital multiple times for violent behavior after being awake several days in a row. He describes Frank's home as "destroyed," with shattered glass scattered around the trailer and the domicile being in a general state of disarray. Frank's father says he is afraid of his son and what he might do, and he understands law enforcement may need to be present during the crisis specialist's assessment. After contacting local law enforcement, the crisis specialist goes to Frank's home accompanied by two police officers.

Upon arrival to Frank's home, the crisis clinician sees two men in the driveway engaged in an apparent argument, a car between them. The younger man can be heard yelling from a substantial distance, though what he says is unclear. The officers tell the crisis clinician that Frank has been incarcerated several times in the last few years for threats and violence toward his family after ceasing to take his psychiatric medications, and he has a history of harming himself under similar circumstances. As the crisis clinician and law enforcement officers approach the men, Frank gestures and yells at his father that "You old (expletive), you got the (expletive) law out here!" Visibly upset, Frank begins walking toward the crisis clinician and officers shouting that he will cooperate and answer whatever questions need to be asked. When asked why crisis services might have been called out to speak with him, Frank responds with a rambling rant involving his father, racial slurs, and claims that he is Malcolm X. He continues loudly rambling without prompt and frequently gesticulating, saying that "the law" does not want him to run the Underground Railroad. Frank states he has not threatened to harm himself or anyone else and says he does not see or hear things out of the ordinary. He says, "You have no reason to be here and I'm not going anywhere." Frank's father looks to the crisis clinician and officers with fear in his eyes, pleading, "Help me."

Compelling. The crisis clinician pulls one of the law enforcement officers to the side and says that Frank will likely need to be committed due to instilling a reasonable fear of violence to self and others in his father and demonstrating a clear unwillingness to seek treatment. The officer states that Frank is not making threats at this time but concedes that his history of violence toward his family and himself is concerning when paired with his current psychotic rage. The crisis clinician tells the officer, "I think we need to involuntarily hospitalize Frank. I can sign commitment papers which will place a legal hold on him and force him to get emergency psychiatric care. Once I have completed the commitment papers, I will need you to transport Frank to the local emergency room so he can get medical clearance and await psychiatric placement in a secure environment." The officer takes the paperwork and tells the crisis clinician, "That's fine, but we'll need you to explain the situation to him. He's never gone with us easily in the past. We usually end up having to use physical force with him."

The crisis clinician returns to talk with Frank and explains that he is being committed to involuntary hospitalization, during which he will receive psychiatric medication and talk therapy, due to his psychotic symptoms and voiced threats to harm others. Noticing that Frank is showing signs of agitation, the crisis specialist goes on to explain that Frank has no say in this process and that if he is

uncooperative and violent with law enforcement, he will likely be arrested and sent to a state psychiatric hospital. Clenching his jaw and clearly agitated, Frank goes with the law enforcement officers for transport to the emergency department (ED). As he gets into the officers' vehicle, Frank looks at the crisis clinician and yells, "I'm gonna kill you, (expletive)!" The officers drive off to take Frank to the ED for clearance and psychiatric placement. Frank demonstrates impaired insight and judgment due to psychosis, his father and other family members are fearful of physical violence from him, and therefore he has lost any semblance of autonomy to his mental health disorder. The crisis clinician utilized heavy coercion through civil commitment procedures.

Cases like Frank's in which the individual seems likely to intentionally or unintentionally endanger the safety and well-being of self and others while also refusing treatment show disordered autonomy and require restrictive crisis interventions. Thus, the crisis clinician committed Frank and compelled him to involuntary psychiatric hospitalization. By taking this course of action, the crisis clinician made a difficult decision for Frank that he could not or would not make himself in order to help him regain his ability to make reasonable decisions for himself (autonomy), protected Frank from the inevitable, long-lasting, and dire consequences of his threats (beneficence), concluded that non-intervention or inaction would lead to possible death or injury and therefore protected Frank and his family (non-maleficence), and kept Frank's family free from infringements on their liberty and well-being (justice). The crisis clinician further practiced ethical clinical skills in collaborating with law enforcement. Since they had fairly extensive experience with Frank, it was important to involve them in discussions to ensure that they agreed that commitment was the most appropriate and fairest decision to make (justice).

Discussion

A Critical Analysis of Coercion in Crisis Management

The above case studies illustrate how crisis intervention clinicians respond to a continuum of threat posed by individuals to themselves and others. We attempt to be clear that coercion is used in all three cases of conversing, convincing, and compelling. We are mindful of important critiques of psychiatric and psychological practices, especially critiques of the exertion of forceful interventions such as we describe above, and we think that these critiques are important to understand and respond to in the context of crisis intervention practices. Following Bracken and Thomas (2010), we find that comparing and contrasting the approaches of Thomas Szasz (1960; 1974) and Michel Foucault (1965; 1977) usefully informs a critical exploration of coercion in crisis intervention.

Bracken and Thomas (2010) state that while Szasz and Foucault both critique psychiatric and psychological knowledge and practice, they do so in ways that are relatively less helpful (Szasz) and more helpful (Foucault) for those who wish to critically examine their own professional practices. In Bracken and Thomas' view, Szasz's thinking is heavily predicated on the use of binary structures (i.e., Biology/Social science, Individual/State, Body illness/Mental illness, and Freedom/Coercion) in which the first item in the binary construct generally inhabits a position of privilege and is therefore considered "normal" or "better." For Szasz, biology prevails over social sciences like psychology, the will of the individual carries more weight than the will of the state, physical illness is more important than mental illness, and most importantly the prospect of freedom takes precedence over coercion. It is also worth noting that Szasz believes clearer distinctions should be made regarding the roles of medical and psychological practitioners, as medical staff have the role of healing distress in the physical realm while psychology clinicians are meant to alleviate mental suffering.

By way of contrast, Bracken and Thomas (2010) describe Foucault as an archaeologist digging through layers of conceptual sediment and uncovering the historical development of methods for dealing with and talking about psychological distress. Whereas Szasz uses the history of psychiatry to lend ideological superiority to medical practice and freedom, Foucault looks at history to describe the development of our cultural assumptions and how they inform our present and future practice. By

demonstrating the development of the psychiatric complex through the history of asylums in Europe and in his examination of the history of the prison, Foucault (1965; 1977) reveals the rise of disciplinary power, which reconceptualizes power from something wielded by the state to quell individual freedom through brute force to something exercised by trusted professionals to discipline the body and behaviors of individuals via clinical practice. Foucault (1977) suggested that power and knowledge are inextricably related, that “power and knowledge directly imply one another” and that “there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (p. 27). From Foucault’s perspective, the construction of any knowledge, including knowledge about the mental life of human beings, is simultaneously a construction of power relations that tend to limit and control those who do not actively participate in the power/knowledge constructions—in this case, the non-experts of mental health.

The essential difference between the two approaches is that one tends to fall into rather simplistic and naïve dichotomies (Szasz) while the other can be used to usefully frame questions that challenge the state of affairs in a disciplinary or professional practice (Foucault). As Bracken and Thomas (2010) suggest, one way of looking at Foucault is that he “does not position psychiatry as something bad, or wrong, but instead shows that its history is not a necessary one, that is, something that simply had to develop the way it did, according to a logic that is independent of particular human interests” (p. 223) and that in his critical analyses, Foucault outlines a historical progression in which “problems with our behaviors, relationships, beliefs, and sexualities show up not as religious, spiritual, or moral issues, but as technical problems that are open to examination, classification, analysis, and intervention by suitably trained experts. Although this has brought benefits, there are also losses and losers in this process” (p. 226).

In a similar way, we are not positing that the use of coercive practices in crisis intervention simply had to develop the way that it did. We recognize that modern crisis intervention practices have arisen, along with other psychiatric and psychological practices (e.g., the medicalization of psychiatry), in an overall movement toward a view of human experience as a problem solvable by suitably trained experts—and that *though this has brought benefits, it has also produced losses, and losers, particularly for those who have been historically disenfranchised, those who traditionally have not actively participated in the construction of power/knowledge*. The experiences of the writers of this article are limited in that their practice of mental health crisis management has occurred in a primarily Caucasian and Westernized setting, necessitating discussion of crucial cultural issues dealing with coercion across diagnostic, geographic, and demographic borders. One population subset of particular interest in regards to coercion is people with serious mental illness (SMI) like major depression, bipolar disorder, schizophrenia spectrum disorders, and personality disorders. Findings indicate that people with SMI have been misrepresented in legislation as being deviants and thus have historically been unfairly subjected to coercive measures of reproductive control like sterilization (Perry, Frieh, & Wright, 2018).

Interview results from clients subjected to coercive measures in Norway indicate that dominant themes reported by clients include powerlessness and a need for systemic change (Norvoll & Pederson, 2006). Women in particular have been subjected to unethical treatment through coercion and involuntary hospitalization as seen with the abandonment crisis in India wherein the disciplinary power of “family” has left many divorced women committed in perpetuity (Pinto, 2009), showing the need for a continual Foucauldian re-examination of pre-existing and privileged gendered modes of practice. In addition to gender inequality, literature on coercion also indicates issues of misunderstanding cultural values between races which often lead to mis-diagnosis and thus mistreatment, as is the case of culturally appropriate “Black paranoia” of White clinicians (Whaley, 2001).

The debate continues: Some professionals argue that commitment rates are too high (Wynn, 2018), some outright criticize the use of coercion (Lorem, Hem, & Molewijk, 2014), and others state that autonomy has been wrongly prioritized over other ethical values (Lepping, Pamłstierna, & Raveesh,

2016). A frequent but erroneous Szazian view is that there must be an absolute respect of the autonomy of the service recipient such that no interference is justified; this is problematic in situations where service recipients are incapable or unwilling to make responsible decisions which results in de-humanization of that individual (van den Hooff, & Goossensen, 2015), and contradicts the ethical principles of beneficence, non-maleficence, and justice toward others. This concerning attitude of non-interference could reflect a political change in health and mental health practice (Richardson, Bishop, & Garcia-Joslin, 2018; Sugarman, 2015) that may prove detrimental to both service recipients and crisis-involved professions entirely (Whyte, 2017). We question whether autonomy should receive privilege over other ethical values such as beneficence, non-maleficence, and justice; we suggest, rather, that the values must all be considered in the context of one another (Lepping, Pamlstierna, & Raveesh, 2016; WHO, 2015; Beauchamp & Childress, 2001).

Moral Distress

At the macro level of academic research, debate about coercive practices continues to flare; at the micro level of the individual crisis intervention clinician, the internal debate can be debilitating. Crisis management clinicians, by the nature of their work, experience high-stress situations frequently and must balance the seemingly contradicting demands of ethical principles which can lead them to embody moral distress. Austin (2012) defines moral distress as “the name increasingly used by health professionals to refer to experiences of frustration and failure arising from struggles to fulfill their moral obligations to patients, families, and the public” (p. 28). Austin’s definition accentuates clinician perceptions of failing to fulfill *all* ethical principles of crisis management, creating cognitive dissonance and job frustration. Crisis cases such as Shawnda’s demonstrate that managing seemingly competing ethical demands can end in an unpleasant way, as it can leave service recipients frustrated with the clinicians who, weighing options, had to be responsible enough to decide to constrain people’s freedom when necessary.

Crisis clinicians, as empathic mental health professionals, can understand the traumatic circumstances surrounding mental health crises from a client’s point of view. A client may experience the “choice” of accepting voluntary treatment or enduring commitment as no choice at all, and crisis clinicians can deeply and empathically feel the client’s feelings of being powerless. It is no wonder, then, that a worker’s sense of autonomy or personal agency can weaken in the face of high-stress work and competing moral and ethical principles (Theorell, & Karasek, 1996). This weakening of a crisis clinician’s sense of professional autonomy paired with high moral sensitivity, or “an understanding of patients’ vulnerable situation as well as an awareness of the moral implications of decisions that are made on their behalf,” has been shown to lead to higher levels of occupational frustration and more frequent thoughts of quitting one’s profession (Lützen, Blom, Ewalds-Kvist, & Winch, 2010, p. 216). In short, crisis intervention specialists are particularly susceptible to professional burnout and while burnout has been generally studied in mental health counselors (Lee et al., 2007) and social workers (Newell & MacNeil, 2010), there does not appear to be much research specific to burnout in crisis management clinicians.

Implications for Research and Practice

Crises will continue to occur, and mental health responders stand as the vanguard at the intersection of individual and community rights. It seems, then, that until society makes the next great advancement as a people, coercion will remain a “necessary evil” in crisis work, and clinicians must be trained to use it in the most respectful and empathetic ways possible, maintaining a therapeutic stance with clients. In addition to the client perspectives mentioned earlier, it can be helpful to examine clinician-perceived deficits within crisis management. In a survey of psychiatric staff across 17 European countries, clinicians from multiple disciplines identified the following major challenges to effective and empathetic crisis management: staff management and teamwork, competence, education and training, support from management, and risk assessment (Cowman et al., 2017). Moreover, crisis-specific training

must be offered at all levels of client interaction with crisis services, including medical, mental health, and law enforcement domains (Lloyd-Evans et al., 2018; Cowman et al., 2017; Balfour et al., 2016). Further, research on occupational stress and moral distress demonstrates that lowering a clinician's "moral burden" through professional support, i.e. support from superiors and clinical supervision, can reduce detrimental effects that contribute to the problem of burnout (Lützen et al., 2010; Theorell & Karasek, 1996), indicating a need for further study in the field of crisis work. Issues of support and self-advocacy must not be addressed only in workplaces, but must also receive adequate attention in counseling and social work education programs by teaching soon-to-be mental health professionals the necessity of self-advocacy through self-care practices such as engaging creativity and spirituality, requesting social support from family and friends, and seeking counseling as needed (Newell & MacNeil, 2010). Again, while the professional fields of counseling and social work have produced a robust literature on self-care, little scholarship exists specifically pertaining to mental health crisis clinicians (Edward, 2005).

Since the deinstitutionalization of international mental health systems began and nations gave individuals with acute and persistent mental health issues the opportunity to lead average lives, the use of community-based mental health crisis management has become the principal method of clinical intervention, placing ethical and moral responsibility on the shoulders of professionals involved in crisis management, including medical, mental health, and law enforcement staff. In particular, the counselors and social workers that make up mental health crisis intervention staff are often confronted with ethical challenges when assessing individuals for potential risk of harm to self and others and making clinically appropriate treatment recommendations, which often include—to varying degrees based on individual cases—the use of coercive measures when at-risk individuals refuse or are incapable of making responsible treatment decisions. This use of coercion brings to light conflicting ethical values of autonomy, beneficence, non-maleficence, and justice which stirs significant scholarly debate and gives rise to the occurrence of moral distress and burnout in crisis clinicians. While some writers and scholars are drawn to the binary distinctions made by Szasz, the writers of this article urge a Foucauldian approach of continual self-examination and professional deconstruction which promote evaluating and changing practices as needed, as binary thinking generally proves unhelpful for helping professionals.

Research on the issues of managing ethical challenges, coercion, moral distress, and burnout in crisis intervention has been done internationally in the fields of medicine and psychiatric nursing (Cowman et al., 2017; Hem et al., 2018; Lorem et al., 2014); however, little scholarly attention is devoted to the fields of social work and mental health counseling in the context of crisis work. Thus future research in crisis management should include measuring crisis clinician perceptions of ethical guidelines, studying the occurrence of moral distress and burnout in crisis counselors and social workers, and evaluating how well social work and counseling programs train clinicians to deal with ethical challenges and to self-advocate through self-care practices.

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Allyship: The Responsibility of White Counselor Education

Allies in Addressing Racism and Discrimination

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Abstract

Counselor educators have a responsibility to ensure client welfare in counselor training and this extends to increasing the cultural competence of counseling students when working with clients representing diverse populations. Due to the persistence of inequality and absence of cultural competence in the health and behavioral health settings, People of Color (POC) experience health disparities at alarming rates. This begs the questions about who is responsible for these health disparities and how inequities can be addressed. This Interpretative Phenomenological Analysis (IPA) study examined the narratives of eleven self-reported White Allies who are working to dismantle oppression through their advocacy efforts. Themes from the analysis stated that the participants witnessed overt acts of racism, attempted to use intervention and education-based actions to address the racism, and identified systemic racism as the biggest issue experienced by African American people. Recommendations for counselors, counselor educators, and allies will be included.

Keywords: White ally, racism and discrimination, counselor training.

In the United States, racism and discrimination exists at the individual, interpersonal, institutional, and systemic levels (Henkel, Dovidio, & Gaertner, 2006). Individual racism occurs when discriminatory messages have been internalized by an individual (Jones, 2018). Interpersonal acts of racism may include acts of hate and discrimination targeted upon an individual and/or group of individuals (Henkel, et. al., 2006). Institutional racism includes policies and programming within an organization that is discriminatory and unequal (Jones, 2018). Systemic racism includes discriminatory practices across systems and/or institutions that can impair one's ability to be successful across social structures (Henkel, et. al., 2006). Regardless of the form of racism and discrimination, exposure to these acts of hate can be traumatic, and counseling professionals are called to approach this type of trauma with the same sensitivity as they would with clients who have experienced other forms of abuse (Evans et al, in press; Evans et al, 2018; Evans, et al, 2015).

Individuals and communities exposed to racism and discrimination may report behavioral health issues that include depression, anxiety, increased use of alcohol/substances, poor self-esteem, health complications, and decreased self-worth (Bryant-Davis, 2007; Evans et al, 2015; Forsyth & Carter, 2014). This increase of behavioral health issues without access to culturally-sensitive behavioral health service providers can lead to health disparities for People of Color (Evans et al, In Press; Evans et al, 2018; Evans et al, 2015; Gee, et al, 2012). People of Color (POC) are defined as individuals who are non-White and may include, but are not limited to, African American, Arab American, Asian American, Indigenous, Latinx American, and Multi-Racial American Individuals (Hunter, 2002; Moses, 2016). The term POC is used due to its inclusive orientation and may be used to "form solidarities with other [POC] for collective political, and social action on behalf of many disenfranchised or marginalized people," Moses, 2016, para 9).

Counseling professionals and training programs that do not address the pervasiveness of interpersonal, institutional, and systemic racism and discrimination are at risk for revictimizing their clients (Evans, et al, 2018). Counselors have a responsibility to ensure client welfare and this includes demonstrating cultural competence when working with clients representing diverse populations (ACA, 2014; Sue & Sue, 2013). Cultural competence extends beyond knowledge, skills, and awareness (Arrendondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996). This should also include counseling professionals' work to dismantle systems of oppression and privilege that disempower clients and communities (Sue & Sue, 2013). This call to recognize privilege in addressing oppression is especially relevant for White counselors who may not recognize the power associated with their racial identity. White privilege occurs when unearned advantages are afforded to White individuals due to their association with the majority culture (McIntosh, 1988). White privilege can benefit individuals and communities in the workplace, educational environment, and community (Edwards, 2006). These unearned advantages are also noted in healthcare and behavioral health settings regarding quality and access to care (Hebert, et al., 2008).

Although the counseling profession comprises a majority of White clinicians, clients frequently represent individuals of intersecting identities (Sue & Sue, 2013). This lack of cultural representation can bias the profession and White counseling professions to believe Eurocentric approaches to counseling, counselor training, and counseling supervision are appropriate for all of their clients. Evans et al (2018) found in their study of practicing counselors that a majority of counselors are unprepared to identify and address race-based trauma and discrimination in the provision of counseling services. Within counseling, there is a paucity in the literature on how White counselors may perpetuate racism and discrimination in their counseling practice, how White counselors attempt to identify and address race-based trauma in counseling, and the impact of White privilege in clinical settings (Evans et al, In Press; Phoenix, 1997; Thompson & Neville, 1999). It is imperative that the counseling profession closely examine their training practices regarding racism, discrimination, and client welfare (ACA, 2014). Counseling programs must incorporate methods to equip counselors-in-training to identify and address race-based trauma in their practice. This may be especially relevant to White counselors-in-training who benefit from White privilege and may lack a framework to conceptualize the discriminatory social

issues that cause health disparities in POC (Thompson & Neville, 1999). A profession that calls counselors to serve as advocates and social change agents – allyship development is one method to promote client welfare.

One method to further examine the idea of privilege and allyship is through the narratives of self-reported White Allies who seek to educate and advocate for POC (Evans et al; In Press). A White Ally is defined as an individual who could “be helpful in promoting understanding of or addressing discrimination targeting the participant’s group,” (Brown & Ostrove, 2013, p. 2213). A White Ally represents a population of White individuals who may be equipped to acknowledge and address the levels of interpersonal, institutional, and systemic racism and discrimination in our current era. Counselors who identify as allies can work to improve behavioral health outcomes while promoting cultural competence and working to reduce within-group discrimination (Evans et al, in press). Allies are invested in engaging in self-reflection to promote advocacy and social change for diverse populations (Patton & Bondi, 2015). A counselor ally may be able to identify and address the presence of race-based trauma in the individual, institutional and systemic levels.

White Privilege, Allyship and Counselor Training

White individuals can choose to deny or disregard the experiences of POC by claiming white privilege does not exist (Anderson, 2013; Case, 2012). By denying the presence of white privilege, an individual can identify as the racial majority while dismissing the inequality experienced by POC (Wildman, 1996). This reticence to engage in discussions on race and recognize one’s role in oppression perpetuates the cycle of microaggressions, racism, and discrimination (Ancis & Szymanski, 2001; Boutte & Jackson, 2014; Bryant-Davis & Ocampo, 2005; Howard, 2000). This avoidance also deflects the experiences of POC, contributes to the maintenance of discriminatory cultural norms, and suggests that the responsibility for change rests with the disenfranchised (Howard, 2000). This type of worldview interferes with a counselors legal and ethical responsibility to maintain client welfare and incorporate multiculturally responsive interventions into treatment (American Counseling Association, 2014).

Some White individuals that do recognize the presence of racism and discrimination in our current socio-political structure may struggle with managing their own feelings of guilt and shame (Harvey & Oswald, 2006). For these White individuals, discussions of racism and discrimination may yield reactions that include: 1) perceptions that they are being attacked; 2) maintaining a color-blind attitude; and/or 3) discussing the internalized politics and status of the mainstream community (Boutte & Jackson, 2014). These methods tend to blame unidentifiable others and groups allowing the White individual to not acknowledge their personal responsibility for the persistence of discrimination in the United States.

Well-intentioned allies can unknowingly contribute to racism and discrimination. Edwards (2006) notes:

Individuals who are supportive of social justice efforts are not always effective in their anti-oppression efforts. Some who genuinely aspire to act as social justice allies are harmful, ultimately, despite their best intentions, perpetuating the system of oppression they seek to change (p. 39).

In professional counseling settings, perpetuating a system of oppression may include reinforcing institutional racism by maintaining inequitable policies, practicing tokenism, tone policing, et cetera (Boutte & Jackson, 2014; Saad, 2018). In these examples, the White individual did not leverage their privilege to advocate for POC and maintained oppressive practices.

The counseling profession is comprised primarily of White, middle-class females (Meyers, 2017). A profession that espouses cultural competency, the counseling profession’s workforce and student populations continue to reflect primarily White professionals and Eurocentric professional

practices (Burt, Russell & Brooks, 2016). This discrepancy in professional identity and available workforce demands action. POC can be revictimized or experience feelings of invisibility when their White counselor's privilege causes them to be unaware of or ignore the impact of racism and discrimination (Dowden, Gunby, Warren, & Boston, 2014). One approach to address White privilege in counselor training is through the intentional incorporation of ally development in andragogy.

White Allies

A White ally is an individual who "could be helpful in promoting understanding of or addressing discrimination targeting the participant's group," (Brown & Ostrove, 2013, p. 2213). Allies work to dismantle oppression through antiracism advocacy, a position that requires cultural humility. A White Ally may possess qualities that include good listening skills, recognition that they too are evolving, and a willingness to build relationships and challenge others with their own racial ideologies (UC Berkeley Gender Equity Resource Center, n.d.). Allyship promotes greater numbers of advocates to assist with legislation and equality efforts to challenge societal norms (Kendall, 2003).

Edwards (2006) identified three types of allies, at least two of which are vulnerable to complicity with oppressive systems despite intentions of allyship. The first type of White Ally might include individuals who are personally motivated through friend and/or family affiliations to support POC. These individuals, due to their personal connections, may not be able to recognize institutional racism as their alliance is due to relational connection (Edwards, 2006). The second type of ally includes individuals who may hold altruistic ideologies; however, because they lack a socio-political understanding of the pervasiveness of racism, they may perpetuate racism. Finally, allies who are knowledgeable of social change and can understand the socio-political influences of oppression may be well-suited for advocacy and activism (Edwards, 2006; Saad, 2018). Although all three of these identities may be recognized as a form of allyship, White individuals who recognize the systemic issues associated with racism and discrimination are likely to be most helpful in assisting other White individuals in obtaining an anti-racist identity (Mallott, et al, 2019; Saad, 2018).

Critics argue that White individuals who represent the majority, and oppressive, culture cannot work to dismantle while simultaneously benefitting from the sociopolitical system (Spanierman & Smith, 2017). This has led to ambivalence by some multicultural professionals as to the role of the White Ally in diversity and inclusion work. Lacking personal experiences with racism and discrimination, the methods that promote allyship may also be questioned (Saad, 2018). Without a clear framework for White Allies it is hard to define and conceptualize the efficacy of allyship and its role in multicultural competency and addressing health disparities. Further study of White Allies and effective methods of promoting social change are necessary.

Considering the pervasiveness of trauma associated with racism and discrimination, the counseling profession and counselor educators have a responsibility to consider how White Allies may be cultivated in graduate training utilized in the provision of behavioral health services. Efforts to support ally development and increase cultural competence are noted as imperative in addressing institutional and systemic discrimination (Evans et al, in press). This may include targeted efforts to promote anti-racist communication and services in counselor training and between healthcare providers. With these factors in mind, the purpose of this qualitative research was to use Interpretative Phenomenological Analysis (IPA) to examine the individual narratives of self-reported White Allies in their advocacy work (McLeod, 2011).

Methodology

A total of eleven White Allies participated in this study and examined their experiences of observing racism and their perceived responsibility in addressing the discrimination. Participants completed questionnaires and responses were coded using the IPA design. This study is important as it can contribute to the literature on ally development and responsibility within the White population and

counseling profession. The research question for this study was: 1) What are the experiences of White Allies in identifying and addressing racism and discrimination? The stimulus questions for this study were: a) Please describe an instance for which you witnessed racism and attempted to intervene; b) how have you attempted to address racism and discrimination in the workplace/school setting; and c) what are the biggest issues experienced by African American and Black individuals in our current era? Since this study was part of a larger study and additional data was collected, Appendix A includes the full interview protocol.

Interpretative Phenomenological Analysis

Researchers chose a qualitative, IPA approach for this study because this design promotes the examination of a phenomenon that provides space for individual experience unique to each participant (McLeod, 2011). An IPA method empowers the researcher to approach a topic with deliberate curiosity of a phenomenon while working to suspend their assumptions of what the data may yield (Kvale & Brinkmann, 2009). Adhering to a perspective of the subject as the expert, an IPA design employs an interpretative method to data analysis that promotes “telling the story of what has been found,” (McLeod, 2011, p. 148). With a line-by-line analysis coding process, the researchers attempt to identify the context and psychological factors available within the participants’ responses (Smith, Flowers & Larkin, 2009).

Procedure

Following IRB approval, researchers conducted convenience sampling of White Allies through posting recruitment materials on social media sources (e.g., CESNET and LinkedIn electronic mailing lists). Individuals who were interested in the study were directed to the Informed Consent document. Those who chose to consent were redirected to the interview questions and narrative responses were collected. The researchers collected demographic data including gender, age, race, education, income, and occupation, in addition to semi-structured interview information. Participants were asked to respond to open-ended questions. After completing the questionnaire, subjects were encouraged to review their responses to ensure that the data reflected their experiences. The researchers chose this online method to recruit participants because of the target population identified, the pervasive nature of the research topic, and the strengths of utilizing media technology to collect data (Neuendorf, 2017). Participants were reminded that their involvement in the study was voluntary and they could withdraw from the study at any time.

Participants

A total of eleven self-reported White Allies agreed to participate in the study. All subjects identified as White. Participants included seven (64%) women and four (36%) men. The participants’ ages ranged from 26 to 56 years, with a mean age of 41 years. Nine percent (1) of the participants reported having a bachelor’s degree, 64% (7) reported having a master’s degree, and 27% (3) reported having a doctoral degree. Participants reported that they were employed in education (73%), school counseling (18%), and technology (9%) positions. The variance in education and employment highlight the emerging identity of White Allies in different professions. Income ranged from \$25,000 to \$210,000 with a mean of \$117,500. Participant demographics are visually represented in Table 1. To ensure confidentiality, pseudonyms are used in this study.

Table 1 Participant Information (N=11)

Name	Gender	Age	Education	Occupation	Income
Jane	Woman	38	Masters	Student	25,000
Bob	Man	56	Doctoral	Educator	Not reported
Mary	Woman	42	Masters	Educator	105,000
Fred	Man	40	Masters	Student	26,000
Sue	Woman	29	Doctoral	Psychologist	47,000
Sarah	Woman	26	Masters	School Counselor	42,000
Emma	Woman	41	Masters	School Counselor	210,000
Joan	Woman	40	Masters	Corporate Admin	189,000
Chris	Man	49	Doctoral	Educator	200,000
Chad	Man	36	Bachelors	Administrator	150,000
Beth	Woman	47	Masters	Administrator	50,000

Data Analysis

Data were collected from June 2017 to September 2017. The unit of analysis for this study is participants' typed responses to the questionnaire. The researchers used member checking, a peer review process, and an audit trail to triangulate the data (Creswell, 2007; Lincoln & Guba, 1985). For the audit trail, the researchers placed the raw data into a codebook with ten columns including demographic responses and stimulus question responses (Halpern, 1983). This also included data reduction processes (corresponding notes), synthesis products (method conducted to identify themes) and a summary of the analysis findings (Halpern, 1983; Lincoln & Guba, 1985). The primary researcher maintained a process journal to bracket her personal reactions. An external auditor, a colleague, reviewed the codebook and derived themes. Collaborations continued until consensus was attained.

The IPA six-step method for data analysis was used in this study (Smith, et al., 2009). First, the researchers read and reread each participant response to identify initial patterns. Then the researchers reread the transcripts to discern meaning of the emerging topics and began to identify initial themes. The themes were then reviewed again and compared to the codebook of the raw data to ensure accuracy and interpretation. In this phase of the double-hermeneutic process (Smith, et al., 2009) the frequency of participant responses was identified. Next, the researchers identified a list of themes. This interpretative process was used individually for each of the eleven participants. Once the list was finalized, the researchers conducted a cross-case analysis whereby a total of one theme for stimulus question one, two themes for stimulus question two, and one theme for stimulus question three were produced. A peer

reviewer reviewed the materials to ensure consensus in interpretations. The themes did not change as a result of these discussions.

Research Team

The research team consisted of five counseling professionals. The primary researcher is a White female, counselor educator with over ten years of experience in higher education and qualitative research. The primary researcher developed the interview protocol and collected the data. The second author, an African American female counselor education doctoral student reviewed the data using the Smith (2009) IPA analysis approach and completed the first round of data analysis. Simultaneously, the primary researcher also applied the IPA data analysis method to code the data. Once completed, the two researchers met to compare their responses and discuss the identified codes. Any incongruencies were discussed. Upon identification of themes, the third author, a White female counselor educator and two counseling doctoral students (one student identifies as African American and the other as White) conducted an audit of the identified themes.

All researchers who participated in this study have current and previous experience with qualitative research. Scholars who identify as social justice advocates and allies. The researchers have previously presented on topics including race-based trauma, bi-cultural identity, and ally development. The researchers have a vested interest in diversity related initiatives that address racism and discrimination interpersonally, institutionally and systemically.

Statement of Positionality

The primary researcher, a White woman in her late thirties, believes that White Allies are neglected in the professional literature and can be one of the greatest liabilities in diversity and inclusion efforts. After reading Boutte and Jackson's (2014) *Advice to White Allies: Insights from Faculty of Color, Race Ethnicity and Education*, the primary researcher was struck by an example the authors referenced where White colleagues witnessed a microaggression in a faculty meeting and chose to remain silent until after the faculty meeting to approach the colleague of color and offer their support. This is just one example of the lack of direction for White Allies to engage in effective advocacy work and this paucity is also reflected in counselor training programming. Believing many White individuals, although well-intentioned, are ill-prepared to engage in effective discussions, the researchers hope that studies of White Allies will help to provide guidance and practical suggestions for majority identifying professionals who want to leverage their position of privilege in working to dismantle oppression.

Results

In conjunction with Smith et al., (2009) data analysis process, a total of four themes emerged from the stimulus questions. Participants identified acts of overt racism when describing their experiences in witnessing racism. Subjects then reported interventions of education and attempts to address the act of racism. Finally, participants identified issues of systemic racism as the biggest issues experienced by the African American community. This section is structured with the primary heading reflecting the stimulus question and subheadings the themes derived from participant responses.

Experience of Witnessing Racism

Participants identified instances in which they had witnessed racism. All of the eleven participants identified personally witnessing racism between two other individuals. These experiences seemed to extend into the educational, workplace, and community environments. Responses included:

Overt acts of racism.

"The most recent was with a white student who made a comment about a black student who might steal something because "you know how they are." (Emma, age 41).

and

"Fellow faculty members made prejudicial statements claiming that Blacks more likely to plagiarize," (Chris, age 49).

and

"As someone that comes from a small town, America (in the north, mind you), it was commonplace to see confederate flags, and witness racial slurs being used," (Chad, age 36).

and

"I was a former HR manager for a small, family owned business. I noticed questionable hiring practices," (Beth, age 47).

In these narratives, White individuals identified situations where they had witnessed both interpersonal and institutional racist acts perpetuated by others. The respondents did not identify examples of intrapersonal and/or systemic racism in their scenarios.

Addressing Racism

Participants identified instances for which they attempted to intervene after witnessing a racist act. Of the eleven participants, eight individuals reported that they attempted to directly intervene while three individuals shared that they tried to educate or persuade other individuals.

Intervention.

The majority of participants (n=8) noted that their reaction to witnessing a racial incident was to directly intervene. Examples included challenging others, advocating for equality, and promoting policy change.

"I bring attention to these comments and provide additional context or an alternative perspective," (Jane, age 38).

and

"I advocated for equitable treatment and access for Black and Hispanic students and their families," (Mary, age 42).

and

"I personally made it a departmental policy to hire with diversity as a goal," (Joan, age 40).

In these examples, the White Allies identified action-oriented interventions to address the situation. This included immediately responding to an individual in working toward addressing the interaction. These interventions align with behavioral strategies and are skill-based.

Education.

Three of the eleven participants chose to introduce education-oriented responses to the racist incident they experienced. Examples included reinforcing professional ethical responsibilities and individual communication.

"I teach multicultural counseling to masters students so my interventions are essentially teaching students the values of the field" (Bob, age 56).

and

"I kept the kid in the after class and had him explain to me what he meant by that comment and then we had a discussion about how hurtful that statement was to his classmate and how incorrect that assumption is. I encouraged him to examine his personal experiences and not believe things that had been said to him by other people and to apologize to his friend," (Emma, age 41).

In these examples, the White Allies identified education-based interventions to address the situation. This included overt and covert methods to promote inclusivity. In these cases, it appears the subjects utilized knowledge-based interventions in an attempt to challenge the attitude of others.

Biggest Issues Experienced by African American/Black Individuals

Self-reported White Allies who identified and attempted to address acts of racism where then prompted to identify the three biggest issues currently experienced by African American/Black individuals. All eleven participants identified issues associated with systemic racism as pervasive issues experienced by the African American/Black community. Responses included:

Systemic racism.

"Systemic racism (inequality in access to quality education, healthcare, neighborhood resources, etc.) is an issue since its existence is often denied," (Jane, age 38).

and

"Laws that were put in place that knowingly cause problems for the black community," (Emma, age 41).

and

"Systemic racism that favors white Americans that is embedded in our society and it impacts housing, criminal justice, education, health, etc," (Joan, age 40).

and

"The fact that we're still only about 50 years removed from segregation that has left a large portion of black people in communities and environments that aren't built for success. I very often hear white people say that, "the playing field is even now", or things along those lines. What isn't considered is the fact that African American families are generations behind in terms of familial success in careers and education," (Chad, age 36).

In these responses, the participants highlighted their awareness of systemic issues that may impact the African American community. These macro issues may negatively influence experiences in education, workplace, and community settings.

Discussion

This study examined the narratives of White Allies who reflected on their experiences of observing racism and discrimination as an individual and how they attempted to intervene. By identifying the biggest challenges experienced by the African American community, White Allies discussed the larger systemic issues that lead to continued inequities and oppression. Personal experiences in witnessing acts of racism and discrimination were described. In addition, participants acknowledged the pervasiveness of systemic racism and discrimination. The subjects identified interpersonal and institutional acts of racism in their experiences of witnessing racist acts. Issues associated with systemic racism included access to equitable education, healthcare, laws, social norms, et cetera were identified as the prominent issues experienced by African American/Black individuals in the current era.

In consideration of the literature, the responses from this study align with Boutte and Jackson's (2014) findings that White individuals tend to respond with defensive, color-blind, or social blaming tactics in discussing race. In this study, the participants' responses tended to reflect both color-blind attitudes and identified only systemic racism (i.e., social norms) for the primary cause of racism and discrimination. Although true, these findings suggest that the participants, even those who identify as White Allies, may have simplistic perspectives rooted in privilege for how they conceptualize racism and discrimination in the United States. This too aligns with the criticisms of ally work and a lack of understanding as to the dynamics and structure of oppression.

This study suggests that further study is needed on anti-racism and ally development, which are important for examining the responsibility of counselor educators and counselors-in-training in multicultural education and counseling. As Braun Williams noted, "As the numbers of diverse individuals and families continues to grow, counselors will increasingly find themselves faced with complex racial problems in their practices" (1999, p. 35). A complex issue remains as to the role of the White ally in working to leverage their privilege in dismantling oppression.

One consideration to explore with the issue of ally work is for counseling programs to prepare their students to be able to engage in discussions on racism and discrimination in counseling (Evans et al, 2018; Moss & Davis, 2008). Opportunities that promote engagement and dialogue in addressing issues of interpersonal, institutional, and systemic oppression are needed (Boutte & Jackson, 2014). White Allies have the potential to engage in same-race dialogues with other White individuals who do not embrace an ally identity. Although some training approaches exist to empower White individuals to leverage their racial identity in addressing racism and discrimination, these approaches are not endorsed by the counseling community, nor are they supported by a robust base of evidence. A formalized process to assist educators, researchers, and social justice advocates in training anti-racists allies is recommended (Malott, et al., 2019).

Choosing to disengage or withdrawal from discussions on racism and discrimination are harmful, especially when this relates to counseling clients (Boutte & Jackson, 2014). Therefore, it is important for White counselors to be equipped to understand the pervasiveness of racism interpersonally, institutionally, and systemically. By engaging in discussions on discrimination, it is possible that White individuals may experience challenges from other White individuals who may have a differing racial identity philosophy (Helms, 1995; Tatum, 1994). These differing racial identities may be especially notable in graduate counselor training programs where many students are first introduced to the idea of multicultural competence in counseling practice (Evans et al, in press).

Counseling programs and counselor educators have a responsibility to mentor and advise counselors-in-training. Leveraging this role, counseling programs have the potential to serve as guides for White counseling professionals to embrace an ally identity while maintaining their multicultural competence and ethical responsibilities. A milieu that can provide support and relationships to continue their work in anti-racism and social change (Tatum, 1994), counseling programs can be the model for

other professions to establishing effective ally practices. The findings from this study calls for continued commitment and responsibility from the counseling profession to develop guidelines associated with anti-racist identity and ally development (Malott, et al., 2019). Although the role of White Allies is unclear, from a legislation and numbers perspective, it is important for White individuals to engage in anti-racism work to promote system change. Counselor educators are called to identify methods and strategies to infuse ally work into counselor training to promote client welfare.

Limitations and Future Research Recommendations

Although there are some interesting outcomes of this study, the limitations must also be addressed. The method for which participants were recruited included a convenience sampling method which may have led to self-selection bias. Thus, the results of this study may not be generalizable to the larger White population. In consideration of the participant data, the respondents all reported obtaining advanced degrees and claimed a higher socio-economic status. This too is not representative of national demographics on education and income. In addition, individuals who do not identify as an ally were not recruited for this study. It could be helpful to collect data on White individuals who do not subscribe to an ally identity to obtain a deeper understanding of White privilege, systemic discrimination and oppression in the United States.

This research can contribute to the paucity of literature that addresses White anti-racism and anti-racism identity development (Malott, Schaeffle, Paone, Cates & Haizlip, 2019). Establishing guidelines to enable White Allies to function as an ally and support to POC has the potential to address behavioral health disparities by increasing the availability of culturally competent qualified professionals. Future research should consider anti-racist identity development methods to support ally work as well as specific approaches to address systemic racism and discrimination. This would include an increased focus on the intersectionality of identities and ally identity development.

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Appendix A

Interview Protocol

Demographic Questions

1. How do you identify your gender?
2. What is your ethnicity?
3. How old are you?
4. What is your highest level of education?
5. If you are employed, what is your occupation?
6. What is your household's approximate combined annual income?

Interview Questions

1. Please describe an instance for which you witnessed racism and attempted to intervene.
2. How have you attempted to address racism and discrimination in the workplace/school?
3. What are the biggest issues experienced by African American and Black individuals in our current era?

**Other interview questions not included as they were used in a different study.

Therapeutic Termination: Translating Clinical Responsibility into Ethically-Informed Practice

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Abstract

Clinical termination is an important aspect of the therapeutic process, yet one that is largely underrepresented in literature across various helping professions. In this article, termination is defined, distinct types of clinical termination are outlined (e.g., clinician-initiated, client-initiated, and forced), and differences in the impact of termination based upon the termination source (unilateral versus mutual agreement) are explored. Further, various reasons for clinical termination are outlined, and the impact of termination on both clients and clinicians are discussed. A case study is presented to illustrate potential ethical considerations associated with the termination process. Finally, clinical responsibility is discussed in order to empower helping professionals to translate ethical guidelines into meaningful and responsible practice.

Therapeutic Termination: Translating Clinical Responsibility into Ethically-Informed Practice

Termination is one of the most important components of the therapeutic process, yet there is limited literature on termination in comparison to other aspects of clinical practice (Jakobsons, Brown, Gordon & Joiner, 2007; Hilsenroth, 2017). According to Vasquez, Bingham and Barnett (2008), termination can include an opportunity for clients and clinicians to review goals, describe important changes that the client has made or incorporated into treatment, and address feelings associated with the termination process. Further, Vasquez et al. (2008) note that, when done well and in an ethical manner, termination is a means of promoting care and can help prevent client harm. By exploring the definitions, types, and reasons for termination, as well as ethical principles and overarching themes drawn from ethical codes regarding termination practices, clinicians can gain knowledge of the ethical and clinical responsibilities that exist to ensure a high level of client care. With this knowledge clinicians can thoughtfully engage in termination practices. Beyond working with clients on the individual level, clinicians can also advocate for clear termination practices to be implemented in a variety of mental health settings.

What is Termination?

Termination can be understood in a variety of ways. First, clinicians can benefit from understanding the definition of the term “termination” and what constitutes termination in the helping professions. Termination can also be understood by type, which highlights where termination is primarily initiated (client, clinician, or as dictated by circumstances). Further, termination can be understood as a process in and through which clinicians have unique ethical responsibilities. By understanding each of these categories, clinicians can better recognize the unique opportunities and responsibilities that exist within clinical termination.

“Termination” Defined

Various definitions of “termination” exist, but the overarching characteristic associated with termination is that it describes the ending of clinical treatment. According to Natwick (2017), “*Termination* is the term for the process when a client is ending services” with a clinician (p. 18). Gelso and Woodhouse (2002) noted that termination can provide a “...permanent or temporary ending” to a therapeutic relationship (p. 346). Younggren and Gottlieb (2008) asserted that termination is the “...ethically and clinically appropriate process by which a professional relationship is ended” (Younggren & Gottlieb, 2008, p. 500). In each of these definitions, the cessation of a therapeutic relationship is acknowledged, but Younggren and Gottlieb’s (2008) definition uniquely highlights the responsibility for clinicians to engage in termination in ways that are ethically and clinically sound. Although termination is typically associated with the end of treatment, Graybar and Leonard (2008) describe termination as a “...bridge (that) stretches from the initial session and presenting problem, across the evolving therapeutic relationship, through each clinical issue, a final goodbye, and beyond” (p. 56). Because of this, there is a critical need for clinicians to understand the process of termination, its impact, and implications for the therapeutic relationship.

Termination Defined by Type

Termination can be unilaterally undertaken by the clinician or client, initiated by the clinician or client and then mutually agreed-upon, or dictated by circumstances. Ideally, it is collaborative in nature with the client and the clinician serving as active participants in the process (Gelso & Woodhouse, 2002; Goode, Park, Parkin, Tompkins & Swift, 2017; Graybar & Leonard, 2008). A foundational conceptualization of the types of termination is provided within the context of the counseling profession by Lanning and Carey (1987), who describe three types of termination: client-initiated, counselor-initiated, and mutual agreement. Forced termination is another type of termination that has also been discussed in termination literature (Aafjes-Van Doorn & Woldridge, 2018). Each type of termination has distinct characteristics and an associated impact upon the client and the clinician (Aafjes-Van Doorn & Woldridge, 2018; Lanning & Carey, 1987; Syracuse University, 2018). While there tend to be commonalities in the process of therapeutic termination, there can also be unique

dynamics and outcomes based on the type of termination (O'Donohue & Cucciare, 2008). Because of this, clinicians hold responsibility to acknowledge both the common and unique dynamics associated with termination type in order to provide optimal care to clients (Graybar & Leonard, 2008).

Termination initiated by the clinician.

Clinician-initiated termination can occur through mutual agreement or unilaterally, and can take place for a variety of reasons (Lanning & Carey, 1987). A positive impetus for a mutually agreed-upon termination occurs when the clinician initiates a discussion with the client and together they make the assessment that the client has reached his/her therapeutic goals, as evidenced by such things as a reduction or elimination of symptoms, increased insight, and coping skills to address possible concerns in the future (Lanning & Carey, 1987; Joyce et al., 2007; Syracuse University, 2018). A less positive impetus for a mutually agreed-upon termination would occur when the clinician initiates a conversation with the client about the clinician's judgment that treatment is appearing to be ineffective and that alternative treatment should be considered. In either of these cases, and in indeed in all forms of termination whenever possible, abrupt termination should be avoided and appropriate referrals should be considered and offered to the client.

Unilateral action by the counselor to choose to terminate treatment must be undertaken with great care, given the potential impact on the client, especially traumatized and fragile clients (Aafjes-Van Doorn & Wooldridge, 2018) and the ethical imperative to avoid abandoning clients (American Counseling Association, 2014). We consider circumstances such as clinician terminating due to serious illness or changing practices in the later section on forced termination. Here, we consider the relatively rare circumstances such as a client refusing to pay or co-pay for sessions, a clinician being seriously threatened or endangered by the client or someone associated with the client, or a client who, after lengthy discussions with the clinician over time, refuses to address the clinician's concern that treatment is ineffective, or in extreme cases, potentially harmful, and that a referral or referrals are needed. In these cases, and again in all cases involving termination, best practices dictate that the clinician engage in substantial consultation and/or supervision to ensure that termination is done in the most ethical manner.

Termination initiated by the client.

Client-initiated termination occurs when the client is the driving force behind terminating the therapeutic relationship (Lanning & Carey, 1987; Syracuse University, 2018). Similar to clinician-initiated termination, client-initiated termination can occur through mutual agreement with a clinician or unilaterally (Lanning & Carey, 1987). Positively, a client may initiate a discussion about termination when they feel that treatment goals have been met and, through discussion with the clinician, a mutual agreement is reached that future treatment with that clinician is not needed, though there may still be referrals to other services provided by the clinician; negatively, they might initiate a discussion about termination due to their displeasure with its course.

Unilateral client-initiated termination also occurs for a variety of reasons; from the clinician's point of view, what often happens is that the client, without notice, stops coming and does not respond to outreach efforts. Clients may feel that treatment was successful or unsuccessful, or anywhere in between. Clients may feel overwhelmed by treatment and threatened by change, or experience anxiety stemming from the belief that counseling is doing more harm than good, which in turn causes clients to terminate counseling (Lanning & Carey, 1987). One specific form of unilateral termination is premature termination, which occurs when a client discontinues treatment before his or her goals have been met (Swift & Greenberg, 2015). As such, premature termination has been connected to a client's perception of pressure to attend therapy, lower education levels, older age, and increased levels of client distress (Anderson, Tambling, Yorgason & Rackham, 2019; Rubin, Dolve & Zilcha-Mano, 2018). Treatment setting (e.g. college and university counseling centers) and diagnosis (e.g. eating disorders and personality disorders) have also been associated with higher rates of premature termination (Swift & Greenberg, 2012).

Among clinicians, client-initiated termination can prompt a variety of feelings such as insecurity, guilt, or even relief (Syracuse University, 2018). Alternatively, clinicians may feel compelled to blame clients for termination, so supervision and consultation may be warranted to fully explore clinical dynamics associated with the termination (Lanning & Carey, 1987).

Forced termination.

Forced termination can occur under circumstances that were planned or that were unforeseen; it can be undertaken at the supervisory or administrative level, and tends to be felt by the clinician and client as something that has been forced on them (Aafjes-Van Doorn & Wooldridge, 2018; Syracuse University, 2018). Serious treatment or boundary violations can be the impetus for forced termination (Youngren & Gottlieb, 2008) and these and other safety concerns can also be a reason for terminating therapy (American Counseling Association, 2014); in these relatively rare circumstances, a clinician fails to recognize or downplays these concerns and a supervisor/higher-level clinical administrator forces the clinician to accept termination and the need to refer the client to another clinician and/or other services as needed.

More common reasons for forced termination occur when the clinician must terminate with clients because the clinician is moving to a different practice, experiencing a career change, or retiring. Additional reasons include the serious illness or death of the clinician, or when a clinician-in-training completes practicum or internship. For the client, they also include serious illness, death or relocation. The client may change insurance and find that the clinician is out-of-network or may lose insurance entirely and be unable to self-pay. Finally, organizational parameters may limit number of sessions (e.g. a university counseling center's limit of eight sessions per student), or the client may be a minor and parent or guardian decides to discontinue treatment (except in states that allow minors of a certain age to consent to treatment).

With forced termination, clients may experience a variety of emotions, ranging from mild to intense (Aafjes-Van Doorn & Wooldridge, 2018). For most clients, forced termination is experienced as a greater loss when compared to client-initiated termination (Baum, 2007). Additionally, forced termination can lead clients to experience anger, anxiety, feelings of abandonment, or even indifference (Aafjes-Van Doorn & Wooldridge, 2018; Syracuse University, 2018). Forced termination can also produce emotional responses from clinicians. For example, clinicians-in-training often feel distress, because of the time limits-based ending of the therapeutic relationship and out of concern for clients' emotional response to termination (Baum, 2008). Furthermore, clinicians who experience forced termination may experience emotions such as guilt, frustration at unfinished business, feelings of loss, sadness, anger, regret, anxiety, or even possibly relief (Baum, 2008; Sherby, 2013; Syracuse University, 2018).

Regardless of the type of termination that occurs, clients and clinicians are each impacted by termination and experience varied emotional responses. Because of this, open communication about the termination process can provide space for clinicians and clients to discuss their emotional responses towards termination (Knox, Adrians, Everson, Hess, Hill & Crook-Lyon, 2011). Clinicians may also seek supervision or consultation to appropriately process their reactions to the termination process. And to reiterate, in all situations where termination occurs, documentation should note the steps taken to ensure that the termination process was ethically sound and that client abandonment and/or neglect did not occur (Natwick, 2017).

Termination as a Process

Termination can be understood as a process rather than a one-time event, and within this process, various ethical duties and responsibilities exist. Conceptualizing termination as a "bridge" (Graybar & Leonard, 2008, p. 56) that stretches from the beginning of treatment to the very end helps clinicians to recognize the level of importance that termination holds within the clinician/client

relationship. Acknowledgment and demonstration of healthy termination can empower clinicians to meet the needs of clients and provide opportunity for discussion of relationship endings. Further, clinicians have a unique opportunity and responsibility to model healthy relational closure, which can provide clients with insight, language, and skills for addressing relational closure that they may not have gained elsewhere. In so doing, clinicians can equip clients for future encounters they have with closure well beyond the therapeutic relationship. Throughout the therapeutic process, clinicians are responsible for using ethical principles as an overarching guide to practice, along with ethical codes specific to their profession, in order to guide clinical decisions. In fact, adherence to ethical guidelines has been directly linked to successful termination (Norcross et al., 2017), which further underscores clinicians' responsibility to translate ethical principles into therapeutically-sound termination approaches. Common terms within ethical principles of clinicians are autonomy, beneficence, non-maleficence, justice, fidelity, and responsibility. Each of these terms will be explored by means of the following vignette to provide a context for which they can be utilized within the termination process.

Vignette: Malik

Malik is a 22-year-old male living in a large urban community in the United States. The third child of emigrant parents, Malik is a graduate student at a state university where he is studying engineering. Malik has sought services from the campus counseling center, where he has received treatment according to the center's 8-session maximum per student per year, to address stress and anxiety related to the transition to graduate school. Malik was skeptical of counseling at first, as his father was opposed to the idea, advising that men handle strain on their own. However, he has found himself connected to his counselor, Susan, a licensed professional counselor working in the counseling center.

During his time with Susan, Malik has found himself able to open up about previously difficult struggles with anxiety. Susan and Malik have formed a strong bond with one another, so much so that Malik has trouble thinking about navigating university life without her. That's why, at a recent session, Malik felt a wave of panic as Susan informs Malik that she has been reviewing his treatment progress and feels he has made sufficient progress to warrant discussion of termination. Susan also reminds Malik that the counseling center typically limits treatment length to 8 sessions and that she has already requested additional sessions from her supervisor, the director of the counseling center. Malik agrees that he feels successful in managing his symptoms, but is loath to terminate the relationship. As Susan continues to discuss termination, Malik announces that he and his new girlfriend are having arguments and he wants to bring her in and begin couples counseling with Susan. While these concerns would be valid topics to address in couples counseling, Susan recognizes that standard clinical practice would dictate that a referral for a different counselor should be given to Malik if he wishes to pursue couples counseling. She senses that his wish to expand the scope of treatment may be an expression of Malik's reticence about ending the therapeutic relationship.

As Susan reflects on Malik's ambivalence about termination and seeks consultation, she identifies ways in which she might have more thoroughly and effectively prepared Malik for the inevitable. While her Informed Consent form indicates that counseling is a time-limited process, and that the counseling center limits the number of sessions a student can receive in a year, consultation highlights that it would have been clinically useful to discuss the process of termination regularly over the previous six months. Regardless, she feels an ethical responsibility to bring the therapeutic relationship with Malik to a close, recognizing the her lack of preparation of Malik for this eventuality may complicate termination.

Indeed it did. As Susan presses termination, Malik begins to shut down and emphasizes that he was not ready to be done working with Susan (unilateral termination, as client is not in agreement). Recognizing the situation, Susan works to balance validation of Malik's frustration with providing information on the natural process of ending counseling. She accepts responsibility for not having

adequately prepared Malik for this over time, she compromises and sets the limit that they will have six more sessions. While Malik's emotional well-being is a top concern, Susan knows she needs to terminate due to treatment outcomes and clinic limits (forced termination). However, she works with Malik on a plan for their six sessions to better support him throughout the transition. Malik agrees to the plan, and seems a little relieved to have a set limit and plan. Throughout the next six weeks, Susan and Malik work with an eye toward next steps. By the end of the sixth week, Malik has begun to establish his own peer-based support system and expresses readiness to transition (mutual termination).

Ethical Principles for Termination

The following are suggestions for clinicians to consider based on ethical principles of the counseling profession.

Autonomy. Autonomy refers to the recognition that clients have the rights to make decisions that they believe to be in their best interest. While Susan may have ideas and suggestions about treatment options, Malik is ultimately responsible for making his decisions about how he uses his success gained in treatment. In order to help Malik remain autonomous, Susan must provide options for termination and especially to make time in session to discuss and process termination options with Malik (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2017). While Malik does not want to terminate, Susan is not compromising autonomy by terminating their relationship as she has provided other, more appropriate referral options for Malik. While continuing in therapy with Susan is not an option, due in part to session limits at the counseling center and more importantly due to her need to follow her perspective on standard clinical practices, Malik is responsible for the future choices he makes in seeking services.

Non-Maleficence. Non-maleficence ensures that providers "do no harm" to their clients. At the most practical level, by practicing ethically, clinicians can prevent harm (Vasquez et al., 2008). By providing a referral, Susan is avoiding harm by not practicing outside her scope of practice. Further, Susan can avoid her client experiencing neglect and abandonment by creating time in the therapeutic process to talk about termination and co-creating a termination plan with the client. Additionally, by avoiding an abrupt termination, which may cause feelings of abandonment and neglect, Susan works to do no harm to her client.

Beneficence. Beneficence refers to clinicians making decisions with the intention to do what is most beneficial for clients. Susan can ensure beneficence by providing an individualized termination plan for Malik (e.g., providing referral options). Further, by terminating the therapeutic relationship with Malik under the rationale of scope of practice issues and knowing that there are other clinicians in the area who therapeutically specialize in Malik's area of need, Susan is attempting to make sure services are as beneficial as possible for Malik instead of continuing unnecessary treatment or treatment that is outside of her scope of practice (Natwick, 2017).

Justice. Justice includes treating clients equitably and fostering fairness and equality (American Counseling Association, 2014). When engaging in all aspects pertaining to therapy with Malik, including the termination, Susan needs to not only provide adequate services, but also create and give access to a termination plan (including referrals). The principle of justice would suggest that clinicians should create an individualized termination plan for each client. Further, as each client's concerns and treatment goals will vary, referral and resources should match client needs.

Fidelity. Fidelity identifies the need for clinicians to honor their commitments to clients (American Counseling Association, 2014). Susan would make sure she is following through with anything discussed in the treatment process with Malik. Specifically, Susan would need to make sure she is following the protocol she created with Malik for his termination plan (e.g. provide time in

session to discuss termination process, provide appropriate referrals, complete appropriate documentation for transfer/referral).

Responsibility. Clinicians are expected to fulfill their responsibilities to their profession, (American Counseling Association, 2014), which at minimum is guided by their respective codes of ethics and codified state laws. Susan is able to demonstrate responsibility by following her specific code of ethics, as well as aligning her decisions with all of the aforementioned ethical principles. These guiding principles set forth the ground work for the following section, which will discuss five themes found throughout a multitude of health professions' codes of ethics specific to termination. A full comparison of ethical codes on termination is found in Table 1, which highlights the key concepts and identified codes within each of the themes discussed in the following section.

Discussion and Recommendations

Based upon consensus from various helping professions, it seems apparent that clinicians maintain responsibility to engage in ethically-sound termination with clients. Because of this, it is important to acknowledge the impact of termination and to recognize the ways that termination can and should be integrated throughout the entire treatment process. It is also helpful for clinicians to recognize termination as a means of advocating for clients.

Termination can have a positive or negative impact on clients, depending on the dynamics that occur during the termination process. In one study, positive termination experiences were linked to a positive clinician-client relationship, clear and thoughtful planning, discussion of termination, and discussion of clients' self-care strategies (Knox et al., 2011). Further, positive termination experiences are associated with mutual engagement in activities that pertain to the termination process (Norcross et al., 2017; Shafran et al., 2019). Additional components of successful termination practices include identifying the client's growth areas, discussing what went well in the therapeutic process, empowering the client to own gains and areas of growth, planning for future growth, and adherence to ethical guidelines (Norcross et al., 2017).

In contrast to this, Knox et al., (2011) noted that problematic termination experiences were associated with those whose presenting concerns were often related to issues of grief/loss, which may have led to more fragility on the part of clients. Further, clients seem to feel dissatisfied with termination when they are not active participants in the activities and processes associated with termination (Shafran et al., 2019). Other aspects of problematic termination include therapy not meeting the expectations of clients, an unresolved rupture in the counselor-client relationship, or lack of planning or discussion about termination within the therapeutic process (Knox et al., 2011). When therapy ends prematurely or without adequate termination, it can lead to feelings of abandonment on the part of the client (Vasquez et al., 2008). Interestingly, findings from Anderson et al. (2019) suggest that client distress, which is often associated with premature client termination, is mediated by the therapeutic alliance, which underscores the value of the client-clinician relationship. When termination does occur, clinicians should address the impact termination may have on both themselves and on clients, as both clients and clinicians can experience emotional reactions to termination (Baum, 2008; Syracuse University, 2018). Further, addressing the emotional impact of termination on both the client and the clinician has been linked with successful termination (Norcross et al., 2017). Because of this, it is imperative that clinicians recognize the divergent responses clients may have towards the termination process and take responsibility to ensure that termination is conducted in an intentional and thoughtful manner.

Clinicians are responsible for addressing clients' needs regarding termination, whether common or distinct to an individual client (O'Donohue & Cucciare, 2008). Because of the impact that termination can have on the therapeutic relationship, effective termination should not be addressed solely at the point of termination, but rather it should be integrated as part of therapeutic dialogue throughout the t

process (Goode et al., 2017; Graybar & Leonard, 2008). Therefore, conversation about termination should be incorporated at the beginning of the therapeutic relationship through informed consent, throughout treatment, at the end of treatment, and when following up with clients who have unilaterally terminated treatment. Although clinicians hold clear responsibility when it comes to client termination, embracing this responsibility helps to ensure that clients receive an ethically-sound, meaningful approach to termination.

Clinicians hold responsibility to ensure that client termination occurs in a responsible and ethical manner. Clinicians should, at minimum, follow their respective code of ethics when making decisions about termination. The codes of ethics associated with various health professions outline a baseline of expectations for termination of a therapeutic relationship (American Counseling Association, 2014; Association of American Marriage and Family Therapists, 2015; American Psychological Association, 2017; Australian Psychological Society, 2007; International Association for Marriage and Family Therapists, 2017; National Association of Social Work, 2017). These codes, summarized in Table 1, are there to assist clinicians in constructing a course of action that best serves the clients who are engaged in and utilizing therapeutic services (American Counseling Association, 2014).

There are many additional practices that can be used to encourage ethically-minded and thoughtful engagement in the termination process. First, discussions about termination should occur throughout the therapeutic process. By talking openly about termination, clients and clinicians will feel empowered to discuss the termination logistics as well as their own emotional responses to termination (Knox et al., 2011). Clinicians should explore how clients are experiencing the therapeutic process throughout therapy and also discuss clients' self-care strategies, which will ensure that struggles and problems as well as coping skills are being adequately addressed prior to initiating termination (Knox et al., 2011). Next, strategies can be used to ensure that documentation and communication promote client wellbeing beyond what occurs within counseling sessions. When engaging in the termination process, clinicians are responsible for ensuring that documentation outlines reasons for termination and adequately describes the termination process (Younggren & Gottlieb, 2008). Additionally, clinicians should attempt to contact clients who miss appointments without notice, by phone or in writing, in an effort to provide an opportunity for collaborative engagement in the termination process (Vasquez et al., 2008). These measures allow clinicians to demonstrate responsibility as they ensure that clients are well cared for throughout the therapeutic relationship and at the culmination of the therapeutic process.

In addition to bearing responsibility towards clients when it comes to termination approaches and practices, clinicians should be mindful of their role as advocates for responsible and ethical termination through their ability to advocate for practices that impact society at large. For many clinicians, this responsibility translates into advocacy efforts on behalf of clients in managed care settings and in interactions with third-party payers. Outside pressures for termination exist, including financial pressure to terminate based upon an allotted number of sessions being paid for by third-party payers and/or managed care organizations, which could potentially lead to premature termination (O'Donohue & Cucciare, 2008; Reynolds, Welfel & Danzinger, 2008). In light of this, outside pressures for termination should not be the motivation for termination, and clinicians should advocate for changes within managed care systems to better support clients and their mental health needs (Reynolds et al., 2008). By doing so, clinicians can keep client needs at the forefront of the termination process while also advocating for clients on a societal level.

Conclusion

Termination, regardless of type, occurs with every therapeutic relationship. While there are multiple types of and causes for termination, all clinicians have an ethical obligation to make sure client care is at the forefront throughout the process of termination. Ethical principles and codes of ethics provide guidance for termination practices. Additionally, clinicians can, and potentially should, use consultation and supervision to address the nuances of client-clinician relationships and client needs, specifically in times of clinician impairment. As clinicians learn to own and practice the highest level of

responsibility regarding termination processes and practices, true benefit can be gained by all parties involved in the termination process.

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**Gatekeeping: A Counselor Educator's Responsibility
to the Counseling Profession and Community**
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This manuscript is loosely based on a situation that occurred at a large university in a graduate counseling program. All identifying information has been changed to protect confidentiality of the student and instructor.

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Abstract

Counseling is one of the few professions practiced in private with vulnerable individuals. Because of this, counselors must be held to high training standards and be deemed competent prior to being allowed to practice independently. The responsibility for ensuring future counselors' competence rests with counselor educators and clinical supervisors via a process known as gatekeeping. This paper highlights the importance of gatekeeping in the counseling profession and describes models of remediation for supervisors and educators navigating this complex process. Utilizing a case study, the authors demonstrate the protective function gatekeeping serves society by applying a gatekeeping decision-making model. Finally, recommendations are provided to increase adherence to and facilitate implementation of gatekeeping responsibilities by counselor educators and supervisors.

Keywords: Gatekeeping, counselor educator, clinical supervisor, ethics, gatekeeping model

The importance of the relationship between client and counselor in which there is trust and confidentiality helps clients to feel safe, as well as be open and vulnerable sharing their experiences. Because of this need for safety, trust, and confidentiality, counseling is one of the few professions that continues to be practiced behind closed doors. Additionally, counselors work with people who are vulnerable mentally, emotionally, and relationally. This can result in harm to clients through negligence or abuse of the privileged position in which counselors work (Remely & Herlihy, 2019). Therefore, those responsible for training counselors – counselor educators – have a grave responsibility to individuals and the community to safeguard vulnerable individuals.

This responsibility is enacted by ensuring that counselor(s)-in-training (CIT) are able to demonstrate competency beyond academic work. In addition to academic competency, CITs are required to, “uphold the standards of beneficence and nonmaleficence: striving to do no harm and protect the rights and welfare of those with whom counselors and therapists interact, especially clients” (Homrich, 2018, p. 5). In order for these standards to be upheld, the CIT is evaluated by counseling faculty and counseling supervisors in what are called *competencies* (Dollarhide, 2013; Miller et al., 2019). These competencies are divided into three domains: *knowledge* (information presented in the classroom/supplemental reading) (Dollarhide, 2013), *clinical skills* (evaluated through observation) (Dean, Stewart-Spencer, Cabanilla, Wayman, & Heher, 2018), and *disposition development* (external behaviors driven by attitudes, values, and beliefs) (DeLorenzi, 2018; Dollarhide, 2013). If the CIT lacks competency, it is the responsibility of the faculty and supervisors to protect future clients, community, and the counseling profession from the CIT in question. This responsibility is commonly referred to as the process of *gatekeeping*. Koerin and Miller (1995) offered one of the first definitions, stating that gatekeeping, “prevents the graduation of students who are not equipped with the requisite knowledge, skills, and values for professional practice” (p. 247). The authors of this article address the importance of gatekeeping in the counseling profession, its impact upon the community as a whole, and offer models of remediation while highlighting the case study of Tanya.

Gatekeeping in Counselor Education and Supervision

The field of counseling requires that CITs develop in the areas of clinical skills and knowledge, but also in dispositions; these include professionalism and self-awareness (Baldwin, 2018a; Dollarhide, 2013). This ensures that a CIT’s future clients will be given effective treatment and will be protected from potential harm, a process known as gatekeeping (Homrich, 2018). Kerl and Eichler (2005) use the term gatekeeping to describe the process in which a person is given permission to enter a field or sector.

Gatekeeping is thought to have originated in the field of journalism, where the gatekeeper would decide which pieces of communication would be printed and which pieces were not allowed through the ‘gate’ (Baldwin, 2018b). In the mental health field, the gatekeepers are graduate school faculty and clinical supervisors, whose responsibility it is to monitor and evaluate progress of the CIT before allowing the individual to enter the counseling profession (Baldwin, 2018b). Gatekeeping in the counseling field prevents what Brear and Dorrian (2010) describe as *gate slippage*. Gate slippage occurs when counseling supervisors and/or faculty members consider a CIT incompetent and unsuitable for the counseling profession, yet allow them to advance into the profession.

The complex obligation for gatekeepers to ensure the protection of the counseling field is one that requires further attention in the professional literature (Freeman, Garner, Fairgrieve, & Pitts, 2016; Homrich, DeLorenzi, Bloom, & Godbee, 2014; Miller et al., 2019). Many attempts have been made to define and conceptualize gatekeeping and CIT dispositions. The literature also highlights the need for the counseling profession to determine conclusive expectations and clearly define gatekeeping and dispositions. Success in these areas may aid counseling programs and counseling supervisors in efficiently collaborating to produce competent counselors, which, in turn, ensures the protection of future counseling clients and the profession as a whole.

Roles of Gatekeepers

The two roles in the professional counseling field that hold the primary responsibility of gatekeeping are graduate counseling faculty and clinical supervisors (Baldwin, 2018b). These two *gates* ensure that future counselors are evaluated and deemed ready to enter independent practice (Bernard & Goodyear, 2019; Gizara & Forest, 2004). As outlined by Homrich (2018), graduate faculty maintain gatekeeping responsibilities while the CIT moves through the process of obtaining a master's degree in counseling. Once the CIT graduates, the responsibility of gatekeeping falls to the clinical supervisor where it remains while the CIT works towards a license. During this two to four-year process, which varies by state in the US, the clinical supervisor monitors the CIT's abilities to function as a professional counselor. The role of gatekeeper during these first years of education and practice is considered so vital that faculty and clinical supervisors can be directly held accountable for any harm caused to clients by a CIT, especially if these issues are known but not addressed.

Through the process of training future counselors, faculty and supervisors are responsible to assess a CIT's ability to interact as a competent and ethical counselor with clients, the community and colleagues (Dean et al., 2018; Miller & Koerin, 2002). Overall, gatekeepers evaluate the CIT, provide feedback that promotes growth, and facilitate opportunities for the CIT to respond and integrate feedback. This cycle continues until the CIT either moves to a higher level of training or is placed in remediation to address deficits (Henderson, 2018). Faculty and supervisors make these gatekeeping decisions: that the CIT's knowledge, skills and dispositions are adequate to move forward, or that the CIT needs additional intervention.

The responsibilities as a gatekeeper encompass professional, legal, and ethical roles. In the United States, these roles are addressed in state laws, accreditation rules, and ethical codes. Sacuzzo (1997) and Homrich (2018) have identified several primary legal responsibilities for mental health gatekeepers. Gatekeepers protect current and future clients' welfare and help ensure no harm comes to them. They protect the welfare of the CIT, and those with whom they interact, such as other CIT and professionals. Gatekeepers safeguard the counseling profession in general. Finally, they protect the reputation of the institution from which the CIT graduates or the agency that endorses the CIT.

In addition to legal consideration, the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) and the American Counseling Association's (ACA; 2014) *Code of Ethics* directly address the role of gatekeeper. As the primary accreditation body for graduate counseling programs, CACREP has established faculty standards and specifically names gatekeeping as a part of clinical training (Standard 6.B.2.1). Definitions for the practice of gatekeeping, knowledge, skills, and dispositions are detailed in relation to clinical mental health counseling programs. All CACREP-accredited institutions must assess each trainee at multiple points in the program, in a systematic manner, to determine progress through the program.

CACREP and the ACA provide the guidelines for faculty and supervisors to train and evaluate a CIT's competencies as part of the gatekeeping process. While CACREP addresses gatekeeping in the education process, the ACA *Code of Ethics* (2014) addresses gatekeeping throughout the entire developmental process. The ACA Code details the responsibilities of supervisors, CITs, and instructors. This includes but is not limited to the responsibility to a) guard client welfare, b) provide clear policies and procedures to the CIT, c) inform the CIT of ethical, professional, and legal responsibilities, d) provide evaluation, endorsement, gatekeeping, and remediation, and e) address CIT personal matters that might affect professional competency (ACA, 2014). The Code specifically addresses faculty roles, as well as the process of evaluation and remediation.

Competencies: Three Key Domains

Counselor educators enact their responsibility to clients, CITs, and the community by providing instruction, training and mentoring for CITs. Counselor educators must address three key areas of

formation during the CIT's developmental process: knowledge, skills, and dispositions (Ametrano, 2014). These three domains form a foundation that supports the clinical training that is unique to counseling and other helping professionals (Lambie, Mullen, Swank, & Blount, 2018).

Evaluation of domain one, *knowledge*, is the most straightforward responsibility undertaken by counselor educators (Dollarhide, 2013). This includes information that is presented in the classroom, the choice of textbooks and supplemental reading materials, and the assignments that serve to both increase knowledge and assess what information the CIT internalized (Ametrano, 2014). CITs report that the knowledge they received in class is foundational to their development (Kimball, 2018). Knowledge provides the groundwork for the professional self.

Domain two, *clinical skills*, is the application of knowledge, and is assessed through direct observation, as well as client outcomes (Dean et al., 2018; Miller et al., 2019; Minton, Gibson, & Morris, 2016). These skills range from basic communication skills to the more advanced integration of theories and assessments (Bernard & Goodyear, 2019; Eryilmaz & Mutlu, 2017). The clinical skills needed to become a competent counselor are vitally important; therefore, CITs are required to complete basic skills courses and continue to be evaluated on these skills throughout internship and postgraduate supervision. CITs are required, in CACREP accredited programs and during the licensure process in some states, to video tape sessions and receive supervisor feedback while engaging in ongoing self-assessment (CACREP, 2015). Counselor educators have the responsibility to assess and promote clinical skills development within the classroom as well as within clinical practice (ACA, 2014; CACREP, 2015).

The third domain, *dispositions*, is more subjective, making it difficult to assess and change (Dollarhide, 2013; Miller et al., 2019). Dispositions are defined as external behaviors that are driven by attitudes, values, and beliefs; these behaviors impact competency in a variety of core areas including ethically and multiculturally responsible practice (Dollarhide, 2013). Therefore, faculty and supervisors have a responsibility to assess and address CIT dispositions. Addressing dispositions is a complex process that develops over time (Miller et al., 2019).

Disposition is defined in various ways, depending on the evaluator's perspective and training (Lambie & Ascher, 2016). This is demonstrated by the attempts to develop standardized measurement instruments to assess CIT dispositions. For example, the Counseling Competencies Scale (CCS; Lambie & Ascher, 2016; Lambie et al., 2018) and the Professional Disposition Competence Assessment (PDCA; Garner, Freeman, & Lee, 2016), which require specialized rater training so that disposition is interpreted and evaluated in a similar manner.

Even with the introduction of standardized assessment instruments, no official definition of the term has been adopted by the counseling profession as a whole (Miller et al., 2019). To assist with the process of standardizing the definition, Christensen, Dickerman, and Dorn-Medeiros (2018) recommended the use of eight common terms used by CACREP accredited institutions in retention policies, handbooks, evaluations, and disposition rubrics. These themes provide a foundation to build a consensus of the term *disposition* and the primary areas for CIT assessment. Miller et al. (2019) provided specific components for the term within a three-tiered framework. Disposition was reported as a single construct with two underlying factors, personal and professional disposition, and nine correlating factors. In the end, both research groups cautioned that all factors impacting disposition may not have been accounted for in full. In addition to the difficulty and lack of agreement in defining dispositions, this competency is slow in changing (Dollarhide, 2013). This necessitates an ongoing process of examining personal attitudes, values, and beliefs starting in graduate school and continuing throughout the counselor's career (Knapp et al., 2017; Lambie et al., 2011). Due to the lengthy nature of the process of completing a graduate degree, it is often difficult to measure change in dispositions, which makes evaluation even more problematic. Despite the difficulties assessing counseling dispositions, these areas are central to becoming a competent clinician; therefore, assessing dispositions cannot be overlooked (Ametrano, 2014; Hancock, 2014).

Gatekeeping: Timing and Assessment

The gatekeeper role can be accomplished by focusing on gatekeeping in the admissions process as well as evaluation throughout training programs. Gatekeeping for counseling faculty members begins during the admissions process where faculty review the academic and nonacademic qualifications of prospective CIT (Swank & Smith-Adcock, 2014). Swank and Smith-Adcock found that 80% of graduate counseling programs included an admissions interview. These interviews included activities to help assess dispositions including, questions in individual and small groups, experiential exercises, and writing samples. Redekop and Wlazelek (2012) suggest incorporating assessment of dispositions into the application and interview process for graduate counseling programs. Other programs utilize a “matriculation process” (p. 54) where students are granted a probationary acceptance into the program, and then evaluated at set times. During these reviews, CIT competencies are considered and a decision on full admission to programs made. One barrier to effective gatekeeping in the admissions process identified a lack of reliable measurement instruments to assess dispositions.

When reviewing the variety of assessment instruments in the literature, two stood out due to having good psychometric properties and continued refinement. The CCS’s main goal is to measure CIT skills, behaviors, and disposition. It has demonstrable reliability as a tool for clinical supervisors when assessing student dispositions (Lambie & Ascher, 2016; Lambie et al., 2018; Swank, Lambie and Witta, 2012). A second assessment, the PDCA, is a tool counselor educators can use to assess and possibly help develop CIT dispositions, starting at admission and continuing until graduation (Garner et al., 2016). Both of these assessments were found to have good interrater reliability when initial training and ongoing “booster” sessions focused on scoring were completed. In addition to assessment instruments, multiple models of gatekeeping exist to aid counselor educators in this task.

Models of Gatekeeping

One of the earliest models of gatekeeping was created by Bemak, Epp, and Keyes (1999). The first step in their five-step process is to clearly communicate the program’s policies and expectations to the CIT. In addition to guidelines about academic performance, program expectations about dispositions (e.g., appropriate interpersonal skills, healthy relationships, empathy toward others, the capacity to explore self, and seek personal growth) are clearly communicated to prospective and current CITs (Bemak et al., 1999). In the second step the CIT signs a contract indicating they understand and agree to follow the procedures, acknowledging the explicit statement, “the student must, in the professional judgment of the faculty and clinical supervisors, be free from any psychological impairment which may act as a barrier to effective professional counseling” (Bemak et al., 1999, p. 25). Step three in this model involves ongoing faculty assessment of the CIT and sharing concerns or problematic behavior with the other faculty when it arises. In step four, when concerns arise, the faculty member meets with the CIT and their advisor to discuss the observations and deficiencies along with a plan for CIT improvement. The model explains the importance of due process, wherein the CIT has a chance to discuss their views, challenge the remediation plan, and make an appeal to the dean. In the final step, faculty conduct ongoing assessment of progress and give feedback to the CIT. If the CIT does not make the required progress, the CIT’s grades are impacted, and the CIT can challenge the grade through the university’s appeal process. This five-step process is time consuming, requiring faculty commitment and follow through, and predicated on faculty and site supervisor agreement to use the model (Bemak et al., 1999).

Wilkerson (2006) offered a model of gatekeeping that was designed to mimic the therapeutic process. The first component is similar to informed consent. In training programs this involves providing the CIT with the policies and procedures of the program, requirements, reasons a CIT may be terminated from a program, as well as potential risks and benefits for the CIT (Wilkerson, 2006). The CIT then signs a document agreeing to the program’s policies. The second component is similar to intake and assessment. The program screens CITs through an admissions process to determine if they are ready to begin the program. Similar to evaluation in counseling, the third component involves

formative and summative evaluation by faculty to determine where growth is needed. Faculty track CIT progress toward improving in these areas. The fourth component is similar to treatment planning, in that counselor educators create a remediation plan to help the CIT grow in professional dispositions in areas where they are presently struggling. The final component is termination, wherein the CIT has either met the goals and proceeds to graduation, or is dismissed due to sufficient progress. In all of these steps, Wilkerson (2006) indicates documentation must occur throughout, just as documentation occurs in counseling at each point of client contact.

DeLorenzi's (2018) model addresses due process in gatekeeping using three-steps. In the first step, the counselor educator or supervisor communicates their concerns to the CIT in a way that is timely, clear, and consistent with published standards. The second step involves meeting with the CIT to explain the concerns that the faculty member has, giving the CIT time to explain their perspective, providing the CIT information about ethical codes, laws, program policies, or other information related to the problematic behavior, and observing whether the CIT is open to making changes. Step two involves the creation of a remediation plan to help the CIT grow in the identified areas. In step three, faculty check with the CIT and determine if the remediation plan needs adjustment. If the CIT does not meet plan requirements, faculty then decide how to proceed. In this step, the CIT is also given information on how they can appeal a decision. By giving CITs a voice in the process, not only are due process requirements met, but CITs may be more likely to "buy in" to the remediation process.

Finally, Letourneau (2016) created a decision-making model for counselor educators to use when they encounter problematic behaviors in CITs. The first step is recognizing the problem and collecting information from the CIT in question, other faculty, supervisors, and other CITs. This step explores the graduate program's impact on the CIT and how the CIT influences the graduate program (Letourneau, 2016). Next, faculty define the problem and identify the conflict; faculty may consult ethical codes, accreditation standards, or other lists of competencies to determine if the CIT is meeting expectations. Faculty determine those affected by the CIT's impairment and related cultural factors. Step three focuses on developing a potential course of action and how progress will be tracked. Letourneau (2016) emphasized that faculty should "consider intrapersonal actions (for the student), evidence of desired changes in intrapersonal behaviors, and what actions may be implemented on the system in response to the problem" (p. 213). In the fourth step, faculty decide on the course of action which consider the CIT's welfare, the wellbeing of clients and the entire group involved. The course of action is reviewed and multiple perspectives, such as "emotional, rational, cultural, and social influences" (Letourneau, 2016, p. 214) are explored in step five. This step also examines the proposed plan from multiple systemic levels including: the intrapersonal level (what was occurring within the CIT), the interpersonal level (what was happening between people), the group as a whole (how the system is impacting the CIT and how the CIT then impacts the system), and the supragroup level (whether oppression blindness was occurring). In the sixth step the plan is implemented and evaluated to determine effectiveness and if other problems occurred (Letourneau, 2016). For the final step faculty continue reflecting on how the plan worked, the consequences of the plan, and what previously unknown variables influenced the plan (Letourneau, 2016). This last model will be applied to the following case study.

Case Study

Tanya is a faculty member in a Clinical Mental Health Counseling graduate program that educates and prepares CITs to become licensed professional counselors. One of the courses she is assigned to teach is counseling internship, which is designed for practical, hands-on experience in counseling. This course is the last to be taken before graduation. Toward the beginning of the semester, a CIT who had been open about her Posttraumatic Stress Disorder (PTSD) diagnosis (stemming from a traumatic event that occurred ten years prior) approached Tanya to speak with her. The CIT shared that her recent interactions at the internship site have resulted in overwhelming anxiety. She stated she is frustrated with her site supervisor because he is not offering her sufficient support. She commented, "I'm tired of it, and honestly, I'm willing to just give up at this point." Tanya reminded the CIT of her

contractual responsibility to the internship site. She also promised to speak with the site supervisor in hopes of mediating the problems.

The following week, Tanya met with the CIT's site supervisor. The supervisor informed Tanya that the CIT was missing scheduled appointments. He also stated that the CIT struggles to take responsibility for shortcomings on paperwork and her generally unprofessional behavior. Tanya confronted the CIT who admitted that her anxiety resulted in her avoiding appointments. She stated, "On top of my anxiety, I have been dealing with my PTSD symptoms" without elaborating further. Tanya then met with her program director and detailed the situation, including past meetings with the CIT and site supervisor and her plan for future meetings. The program director approved the plan to address the identified concerns.

A few days later the site supervisor, CIT, and Tanya met together. The site supervisor said, "Although you have demonstrated unprofessional behavior, your clinical work with clients has been fine; so I am willing to overlook the unprofessional behaviors so you can graduate. Once your internship is completed, you will need to find another place to work." Tanya felt uncomfortable with the site supervisor's goal to get the CIT to graduation and then send her somewhere else to work. In the weeks following this incident, the CIT began to show unprofessional behavior in the classroom by demanding extensions on assignments. When Tanya informed the CIT that she could not give unapproved extensions the CIT responded via email, "I'm so sick of you!" Taken aback by the CIT's behavior, Tanya began to explore the best way to move forward.

In this case study, Tanya saw the need to remediate the CIT's unprofessional behavior. Tanya felt the weight of her gatekeeping responsibility to ensure current and future clients safety (Saccuzzo, 1997). This directly conflicted with the site supervisor willingness to endorse the CIT for graduation, knowing the ongoing dispositional problems. Tanya's process of gatekeeping is described next.

Chosen Model of Gatekeeping for Tanya

This section will apply Letourneau's (2016) gatekeeping model to the case study above. This model was selected because of its ease of use, incorporation of ethics, and integration of multicultural factors related to the CIT. As described in the case study above, Tanya completed the first step by collecting relevant information from the CIT and her site supervisor to gain a clearer understanding of the current problems. Tanya discovered that the CIT was experiencing debilitating anxiety and PTSD symptoms that prevented her from attending scheduled sessions and resulted in additional complications at the site. Tanya determined that the CIT was practicing counseling while impaired, which is an ethical violation according to the ACA *Code of Ethics* (2014). The CIT was determined impaired based on unaddressed mental health symptoms that prevent her from being "fully present" or effective in her work with clients, leading to client harm. At this step, Tanya considered those affected by the impairment and how multicultural factors were involved (Letourneau, 2016). As previously described, Tanya determined that the CIT's current and future clients would be impacted by her mental health concerns, as well as her peers, colleagues, and site supervisor. Tanya also considered the CIT's personal history and how this may have impacted the symptoms the CIT was experiencing. As Tanya considered this step, she decided that the CIT was not meeting internship expectations by not attending scheduled sessions, not consulting with her site supervisor when problems arose, and engaging in unethical practice by continuing to counsel while impaired. At this point Tanya moved past her uncertainty about the need for gatekeeping and moved into action.

Tanya discussed how to best support the CIT and address her mental health symptoms with her university administrator, other counseling program faculty, and the CIT's site supervisor. In these meetings several ideas were discussed to determine possible courses of action. Tanya suspected that the CIT had not received sufficient care for her mental health symptoms and trauma history. Furthermore, Tanya believed the CIT's mental health problems were the root of the problematic behaviors at the internship site.

In deciding on the course of action, Tanya and the university chose to create a remediation plan for the CIT. This plan began with asking the CIT to withdraw from her internship for the semester and engage in personal counseling to address her mental health symptoms. The remediation plan required the CIT to learn more about and engage in various self-care activities (a requirement of the *ACA Code of Ethics* [2014]), and to document this regularly through journaling. The CIT was required to write letters (that were to be submitted to the university program) to the people who may have been harmed by her actions while she was impaired. The CIT was required to meet periodically with her assigned faculty advisor to discuss her progress. After the faculty advisor and the CIT's counselor concluded that the CIT had made sufficient progress and was capable of counseling again she would reenroll in the internship course.

Tanya and her fellow faculty members believed that in this case, the CIT was not currently experiencing oppression, but that she likely did not have access to appropriate services when she experienced trauma, which may have substantially affected the development of PTSD symptoms. Tanya and her peers also considered the degree that the CIT had felt supported and comfortable approaching faculty and supervisors for guidance. Tanya believed the CIT might have felt isolated which created a barrier for the CIT to seek the needed support.

Tanya and other faculty members (including the CIT's faculty advisor) met with the CIT, explained the remediation plan, and provided her a copy in writing. The CIT was asked to provide input about the plan, as part of due process. The CIT agreed to the plan and explained that she believed personal counseling would be beneficial. The CIT met with her faculty advisor regularly (approximately once every three weeks) as she engaged in the remediation plan. The CIT asked her counselor to check in periodically with the faculty advisor to provide progress reports. Although the letter writing was challenging for the CIT, she stated that the exercise helped her have a better understanding of her actions and the possible impact on clients and colleagues. After approximately nine months, the faculty advisor and the CIT's counselor determined that the CIT had met all of the remediation requirements. The faculty observed dispositional changes in the CIT, including a greater understanding of her actions, her responsibility for professional development, and the importance of facilitative communication, empathy, and modeling.

As the CIT completed her internship, the faculty continued to monitor her progress while keeping regular contact with the student's site supervisor. The CIT requested to continue individual counseling, albeit less frequently, as a way to continue her growth process and engagement in self-care. The CIT completed her internship and received positive feedback from her site supervisor, clients, and colleagues. The faculty reflected a final time on the remediation process for this CIT, and determined that the CIT grew a great deal because of remediation through the gatekeeping process.

Discussion and Recommendations

As discussed in the foregoing article, and demonstrated in the case study, counselor educators and supervisors need to have a thorough understanding of gatekeeping that includes the relevant ethical codes and standards related to this role (Johnson et al., 2008; Kaslow et al., 2007). Educators should also consider regulatory and legal aspects when they are assessing a CIT's competence (Kaslow et al., 2007). For example, it is important to be aware of laws related to a CIT's rights to privacy and confidentiality when faculty are communicating with a site supervisor (Kaslow et al., 2007). In the case study, Tanya remained aware of the CIT's right to privacy while gathering information and formulating a remediation plan with the site supervisor.

In addition to increased understanding and awareness, it is recommended that graduate programs and universities actively promote gatekeeping practices. Programs are encouraged to create formalized remediation plans as Tanya did in the case study. Gaubatz and Vera (2002) indicated that programs with formalized remediation procedures had less *gate slippage* compared to programs without formalized procedures. Furthermore, programs with higher percentages of adjunct faculty tend to have

more *gate slippage* (Gaubatz & Vera, 2002). Counseling programs can address this finding by providing gatekeeper training to adjunct instructors. This change can increase inter-department communication, which enables faculty to observe and guide CIT's development throughout the entire program. Continuous and unified communication between faculty and site supervisors supports a CIT's competence development while in practicum and internship placements, and is a crucial component in the gatekeeping process (Kaslow et al., 2007). In the case study, Tanya, a full time faculty member, had the understanding that it was part of her responsibility to communicate often with the CIT's site supervisor, to assess the problem and formulate an acceptable plan for both the school and the internship site. Additionally, faculty who perceive university pressure to avoid gatekeeping tend to avoid engaging CITs in remediation (Gaubatz & Vera, 2002). Faculty can provide education and advocate at their universities about the importance of gatekeeping and the remediation process. Lastly, accredited programs tend to engage in gatekeeping more frequently than non-accredited programs (Gaubatz & Vera, 2002). Seeking accreditation (e.g., through CACREP) is strongly encouraged.

Alongside advocating for changes in university policies regarding gatekeeping, counseling programs should be cognizant of the culture they are creating. Gatekeeping needs to be a substantial component of a graduate program's culture and philosophy. This enables faculty and students to view gatekeeping as an act of responsibility rather than punishment (Foster & McAdams, 2009). Reiterating the ethical mandates for gatekeeping and emphasizing CIT growth during graduate work will normalize and reduce anxiety related to anticipate developmental deficiencies. Faculty engagement in a transparent process of gatekeeping with CITs as well as seeking the CIT's input can promote a more collaborative and less punitive culture related to CIT development. This, in turn, supports a culture that supports and encourages CIT self-assessment, a skill needed to prevent harm to clients and a critical component in gatekeeping (Kaslow et al., 2007). Tanya engaged the CIT through the entire remediation process, seeking to understand the CIT and how best to support her development while making her responsibility as a gatekeeper clear. By modeling the importance of gatekeeping, self-assessment, and ethics, faculty members create a culture where the CIT will be more likely to recognize their own limitations and growth areas, as well as being more responsible to the profession.

Foster and McAdams (2009) advocate for transparency in gatekeeping in counseling programs. They encourage faculty and administration to clearly communicate to CITs the standards of professional behavior, program policies, and potential actions. Clarity in course syllabi, expectations of CIT, routine academic advising, and regular clinical supervision are all ways faculty can incorporate and support transparency (Foster & McAdams, 2009). In the case study, Tanya was transparent with the CIT about expectations related to her performance and demonstration of dispositions. To promote clarity surrounding gatekeeping, faculty members should create operational definitions for competency and explain expected benchmarks (Kaslow et al., 2007). Benchmarks, expectations, and policies must be available for review and should be updated periodically (Kaslow et al., 2007).

Assessment is an important component of gatekeeping for counseling programs. Faculty should regularly provide formative (periodically throughout the course) and summative (at the end of the course) feedback to CITs (Bodner, 2012; Johnson et al., 2008; Kaslow et al., 2007; Russel, DuPree, Beggs, Peterson, & Anderson, 2007). Multiple raters should provide this feedback to ensure that the biases of one instructor does not negatively influence the CITs' growth (Johnson et al., 2008). Since CITs sometimes have difficulty accepting corrective feedback, training should be offered to faculty and supervisors to ensure that they are delivering effective and useful feedback (Johnson et al., 2008). In Tanya's case, she consulted the CIT's site supervisor, other faculty and her director to ensure feedback was corrective and unbiased in nature. It is also important to document the feedback provided (Forrest et al., 2013; Johnson et al., 2008). When CITs are determined to be deficient, faculty must create individualized remediation plans to address these deficiencies (Kaslow et al., 2007). It is important that faculty and supervisors view competence as being neither "a dichotomous nor a static construct" (Johnson et al., 2008, p. 592). Adopting this perspective increases the likelihood of taking a growth

mindset in remediation. In the case study, Tanya created a plan to help the CIT address growth in areas which the CIT was struggling. If faculty and supervisors approach gatekeeping from a fixed mindset, they may inadvertently prevent CITs from achieving competence or success with the remediation plan.

Faculty and supervisors should have a thorough understanding of their roles navigating the complexity evaluating the CIT, while simultaneously advocating for the CIT (Johnson et al., 2008). At clinical sites and graduate programs, it is suggested that measures be taken to separate the faculty/supervisor's mentoring role from the evaluator role by using committees or outside evaluators (Johnson et al., 2008).

It is crucial to consider the individual CIT in the gatekeeping process. Faculty and supervisors should consider CITs' multicultural factors, values, beliefs, and attitudes in decisions about gatekeeping and creating remediation plans (Kaslow et al., 2007). In the case study, Tanya viewed the unique aspects of the CIT, and approached gatekeeping with greater empathy, which helped her deliver constructive feedback in a way the CIT was able to receive. Additionally, this may aid in addressing gatekeeping issues more fully and from a multicultural lens.

In addition to the recommendations provided, faculty and supervisors are encouraged to honestly communicate the CIT's knowledge, skills and dispositions to prospective employers in letters of recommendation (Johnson et al., 2008). Accurate information about a CIT's strengths and limitations helps employers make informed decisions about a candidate's fit with their organization and the clientele served.

In counselor education, gatekeeping is an ongoing process for CITs, initiated during the school admissions process and continuing until the individual earns an independent license to practice. This process ensures counselor educators and counseling supervisors assess and endorse CITs who demonstrate competence in knowledge, skills, and dispositions, and the capacity to engage in responsible clinical practice. By establishing clear and standardized expectations related to dispositions, there will be greater program and faculty agreement related to educator and supervisor gatekeeping roles and responsibilities. As a result, educators and supervisors will work together from a shared understanding, to train and develop competent CITs, thereby ensuring ethical care of clients and a stronger counseling profession as a whole.

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The Development of Professional Responsibility in Counselor Training

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Abstract

Responsibility in the field of counseling is a complex, multi-faceted concept which includes responsibility to the client, responsibility to the profession, and responsibility to the self. These responsibilities encompass the profession's global role, the call to establish consistent professional requirements, the American Counseling Association's Code of Ethics, the developmental process of student skill acquisition and professional identity development, and the curriculum and training requirements of counselor education programs. Following a general exploration of responsibility in counselor education, this article focuses on when and how counselors-in-training (CITs), as they grow in counseling skills and professional identity through coursework and mentoring and supervision, develop a sense of professional responsibility. The survey research method was employed in this study. Results indicated that students felt the construct of responsibility most when preparing for and enrolled in field experience courses. Recommendations are then given to promote the continued development of professional responsibility in CITs over the educational continuum.

Keywords: professional identity, professional responsibility, counselor education

The Development of Professional Responsibility in Counselor Education

Responsibility in the field of counseling is complicated. Arslan (2018) suggests that from a global perspective, the field of counseling in western countries has the responsibility of setting an example for the field of counseling in developing countries. With this responsibility comes the onus to expand the knowledge base through research, further develop professional organizations, establish guidelines for training, review/revise ethical codes, and create and standards for training and continued education and assess counselors-in-training (CITs) according to these standards (Arslan, 2018). As professionals in a western country, viewing the counseling profession from Arslan's viewpoint is daunting. It is a reminder of privilege experienced in western countries and the responsibility that comes with this privilege. Expanding the knowledge base and participating in scholarly work and research is a privilege. Being a model in the counseling profession for other countries is an advantage and an honor. Educating future counselors is a significant responsibility. Teaching, training, and supervising require an awareness of the responsibility of our work as counselors, our work as counselor educators, and the vulnerability of both our clients and our CITs.

From a national perspective, establishing the standards for the counseling profession across states is a pressing responsibility. Olson, Brown-Rice, and Gerodias (2018) investigated professional counselor licensure requirements and the state counseling license application, including the District of Columbia. They found that, across states in the United States, the counseling profession does not have standardized educational requirements, nor does it have consistent training requirements. However, basic educational standards have been identified. For example, Olson, Brown-Rice, and Gerodias (2018) found that courses most frequently identified as educational requirements were courses such as research, program evaluation, and group counseling, which were required on 66% of state counseling licensure applications.

The quest for standardization in many professions results in the establishment of accrediting bodies (Bowers, 2017). Hence, there are two major accrediting bodies in the counseling field. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredits master's and doctoral degree programs in counseling and its specialties that are offered by colleges and universities in the United States and throughout the world (CACREP, 2016). The Masters in Psychology and Counseling Accreditation Council (MPCAC) accredits academic programs that provide science-based education and training in the practice of counseling and psychological services at the master's level, using both counseling and psychological principles and theories as they apply to specific populations and settings (MPCAC, 2015). Along with the goal of establishing consistent educational standards is the need for guidelines or standards addressing "applicants' criminal history, comportment, drug use, mental health problems, malpractice history" (Olson, Brown-Rice, & Gerodias, 2018, p. 102). As previously stated, the profession's responsibility at this level is complex, extensive, and has far-reaching effects.

Responsibility in Counselor Education

While the broader issue of requirement consistency across states is a major concern of the counseling profession, on a regional and local level, the implementation of curriculum and training is the specific responsibility of the counselor educator. Kaplan and Martz (2014) discuss the specific ways in which the American Counseling Association's (ACA) revision of the 2014 Code of Ethics increases accountability and responsibility for counselor educators. Kaplan and Martz (2014) interviewed Shawn Spurgeon, a member of the Ethics Revision Task Force, and highlighted the areas in which the responsibilities of the counselor educator has increased. Some of these ways the responsibilities have increased are:

- 1) The expansion of the responsibility of gatekeeping. The code expands counselor educators' responsibility and now goes beyond the CIT and includes the CITs' future clients which increases the accountability for meeting professional standards.
- 2) A shift of focus from the CIT to the future clients the CIT will serve.

- 3) A counselor educator's responsibility is not just to the CITs in their program, but all individuals over whom a counselor educator has authority and power.
- 4) Counselor educators have the responsibility to network with communities and agencies to provide and evaluate field placement options.
- 5) Counselor educators have the responsibility to provide CITs with employment information and information about employment opportunities.
- 6) Counselor educators have an ethical obligation to provide career assistance to CITs. Spurgeon (in Kaplan & Martz, 2014) indicates that this obligation is clearly supported by the counselor educators' responsibility to be an advocate for their CITs.
- 7) Counselor educators have the responsibility to provide current theories and evidence-based techniques which should include outcome-based research.
- 8) Counselor educators must offer training only within their area of competency.

(Kaplan & Martz, 2014)

As stated above, the focus has shifted from the CIT to CITs' future clients. Inherent in this shift is the counselor educator's responsibility to assess CIT awareness of professional identity as well as CIT awareness of their responsibility as future clinicians.

Professional Responsibility and Ethics

While the 2014 American Counseling Association's (ACA) Code of Ethics expanded the responsibilities of the counselor educator, it also provided clarity for the profession at large. The ACA developed the "following five core professional values of the counseling profession:

- 1) Enhancing human development throughout the life span;
- 2) Honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential and uniqueness of people within their social and cultural contexts;
- 3) Promoting social justice;
- 4) Safeguarding the integrity of the counselor-client relationship; and
- 5) Practicing in a competent and ethical manner." (ACA, 2014, p. 3)

Professional responsibility to live up to these values and to the ethical code lies with the individual clinician and within the field at large. Professional responsibility to teach and assess awareness and understanding of these values and the ethical code lies with the counselor educator.

Responsibility and Professional Identity

Professional identity is considered the integration of professional training, personal attributes, and the counseling values outlined in the ACA Code of Ethics (Gibson, Dollarhide, & Moss, 2010; Dollarhide, Gibson, & Moss; Simons, Haas, Massella, Young, & Toth, 2017). Scholars have indicated that the development of a strong professional counseling identity begins in counselor education programs, and Granello and Young (2019) identified professional identity development as "one of the most important tasks that educators face" (p.vi). Counselor educators, mindful of their increasing responsibilities as outline above by Kaplan and Martz (2014) and aware of their responsibility to teach and exemplify core counseling values, are tasked with disseminating knowledge and modeling professional identity in a structured, coherent program of counseling study. They must focus on who the CIT is becoming, as well as what they know or can do, and requires educators to provide authentic learning experiences such as practice exposure and interaction with role models (Mylrea, Gupta, & Glass, 2017).

The link between professional identity and professional responsibility is direct and strong. To develop a sense of professional identity as a counselor entails developing a visceral awareness of one's responsibility to a vulnerable human being who often is in the worst place of their life. Ethical codes and professional values, while important, offer only the faintest impression of what it is like to assume the responsibility to help a person in distress. It is the responsibility of the counselor educator to bring the counseling encounter to life, vivifying the academic material and ethical codes so that the CIT can begin to understand what it actually means to be a professional counselor. Professional identity and

professional responsibility reinforce one another: to deeply understand one's identity as a counselor increases one mindfulness of one's responsibility to one's clients, and this felt sense of responsibility in turn increases awareness of who one is as a professional counselor.

Of particular interest to this present study is how supervision contributes to the development of professional identity in CITs. Shlomo, Levy, and Itzhaky (2012) found that satisfaction of supervision directly contributed to the positive development of professional identity, and counselor educators can take advantage of the satisfaction that CITs experience in supervisory experiences to promote growth and awareness. Indeed, given the extensive clinical training required by counselor education programs—100 hours of practicum and 600 hours of internship (CACREP, 2009; CACREP, 2016)—and the accompanying supervision by the university supervisor along with the supervision given by the field site supervisor, supervision is a major phase where the CIT develops a sense of responsibility to clients and a sense of what it means to be a counselor. Essentially, the culmination of graduate counselor educational programs is the CIT's development of their professional identity and acceptance of professional responsibility for their work with clients.

Developmental Approach

As with learning, maintaining, and honing counseling skills, the transition from CIT to professional counselor is a developmental process (Hamlet & Burnes, 2012). Developmental perspectives of skill acquisition can be traced from Plato in western philosophy (Ivy & Rigazio-DiGilio, 2009) to Bloom's Taxonomy of Educational Objectives (Bloom, Engelhart, Furst, Hill & Krathwohl, 1956). In the field of counseling, Skovholt and Ronnestad (1995) studied counselor and therapist development and created a developmental model that charted the progression of counselor skill and professional identity acquisition. Ronnestad and Skovholt (2003) reformulated their model to comprise six phases: "the lay helper, the beginning student, the advanced student, the novice professional, the experienced professional, and the senior professional" (p. 5). Following the lay helper phase, which takes place before training, the beginning student phase and the advanced student phase takes place during professional education training programs, while the novice professional, the experienced professional, and the senior professional are considered postgraduate.

The beginning student phase focuses on core tasks such as theoretical and conceptual knowledge acquisition and achieving competence in meeting the content standards set by accrediting bodies such as the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The advanced student phase broadens the professional world of the CIT as they take the knowledge they have learned and begin to practice in supervised field experiences. The postgraduate phase of novice professional focuses on the developmental transition from student to professional. The experienced professional phase is a time of integration of experience, knowledge, theory and technique. The senior professional phase is a time of actualization as a professional.

The Ronnestad and Skovholt (2003) model is a useful lens for viewing the developmental process of CITs. The beginning student phase addresses CITs who are in their true "student" mode. Concerns of CITs in this phase tend to be typical of students in most educational programs. CITs focus on knowledge acquisition, the academic requirements of each class, completing tasks, class attendance and, in essence, meeting the standards set by the professor. During this phase, the CIT has not yet developed the awareness of a professional's ownership of responsibility regarding their role as a professional counselor. Professors often observe CITs desperately seeking concrete answers on how to work with clients. In class, CITs present possible scenarios in counseling and ask for the prescriptive course of action the counselor should implement. Developmentally, CITs struggle with the high level of ambiguity found in counseling and become frustrated with the professor for not providing a single clear answer. The lens of the CIT is that their professors bear the responsibility in counseling interactions. Awareness of responsibility for clients has not yet developed; at best, it is in the infancy stage.

A developmental shift occurs as the CIT enters the advanced student phase. CITs are now entering the field experience phase of study. Overall, this is a professionally exciting yet anxious time for the CIT. CITs have anticipated working with “real” clients throughout their coursework and are now entering the professional realm. During this hands-on phase, a transition should occur in the CIT’s view of professional responsibility. By this time, CITs typically have completed a good deal of coursework, and in the first weeks of field experience they often begin by observing the site supervisor’s work with clients. As they do so, they simply shift professional responsibility from the professor to the site supervisor. CITs now have enough theoretical information to understand the counseling process, but they have not fully developed their professional identity and acceptance of professional responsibility. Counselor educators, in collaboration with site supervisors, make the most of this developmental phase to help counselors-in-training transition professional responsibility from professor/site supervisor to an acceptance of their own professional responsibility. Counselor educators should ensure that acceptance of responsibility is a fundamental concept evaluated in the developmental assessment of counselors-in-training.

Two important concepts that contribute to acceptance of responsibility and professional identity development are locus of control and self-determination. Facilitating awareness and acquisition of these concepts can be used to help CITs move past developmental barriers impeding their progress. Importantly, locus of control and self-determination are evidence-based concepts that provide a point of intervention for CIT struggling with acceptance of professional responsibility. Locus of control, a concept originated by Julian Rotter (1954), refers to the tendency of people to believe that control of behavior resides internally or externally. Locus of control tends to be on a continuum and can vary with the situation (e.g. home vs. work). As a CIT progresses through their educational program, assessing their locus of control and using the insight into a CIT’s individual status provides an opportunity for professional and personal development.

Acceptance of responsibility also requires self-determination. Self-determination is the decision to do something or think in a certain way. Self-Determination theory uses a developmental perspective of motivation that moves from amotivation (absence of motivation) to extrinsic motivation (driven by external forces) to intrinsic motivation (activated by internal forces). “Self-Determination theory defined the role of motivation in the formation and maintenance of identity” (Mylrea, Gupta, & Glass, 2017, p. 5). This theory indicates that high levels of motivation occur when an individual feels competent, related, has autonomy, and that “individuals who experience support and growth in each of these three areas are more likely to have high levels of motivation and to develop and maintain the particular identity in question.” (Mylrea, Gupta, & Glass, 2017, p. 5). Professional identity development incorporates the awareness and understanding of the responsibilities of the newly-acquired professional role. Hence, the role of responsibility in professional development of counselors-in-training touches on the very essence of professional identity and establishing oneself as an independent competent professional.

Research Question and Hypothesis

The researchers set out to explore the following question: when do counselors-in-training become aware of their professional and ethical responsibility for clients? After the researchers reviewed the literature on professional identity development and discussed their individual experiences as both professional counselors and counselor educators, the following hypothesis was generated: CITs in masters-level counselor education programs typically begin to feel the responsibilities of being a professional counselor after they have started their practicum experience, at the latest, during the later portion of the counselor education program, and levels of perceived satisfaction would be correlated with higher levels of professional identity.

Programs in the United States of America accredited by the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) indicated a logical and predictable course sequence in counselor education programs. CACREP only goes as far as to indicate what standards need to be met in the counseling programs to meet the required standards agreed upon by professional

counseling associations, but does not dictate when CITs are required to engage in experiential activity, only that they must have some form of practical experience (CACREP, 2009; CACREP, 2016). The programs surveyed in this study placed the clinical experience courses as one of the final courses in their curriculum.

Method

Research Design

In this study, we used existing data that were collected from an exit survey from a recent graduating group of CITs from CACREP-accredited counselor education programs in a public university in the eastern United States. We used a survey design “to answer questions that have been raised, to solve problems that have been posed or observed, to assess needs and set goals, to determine whether or not specific objectives have been met, to establish baselines against which future comparisons can be made, to analyze trends across time, and generally, to describe what exists, in what amount, and in what context” (Isaac & Michael, 1997, p. 136). Counselor education programs accredited by CACREP are required to complete systematic program evaluation on a regular basis to ensure that standards are being met and the program continues to provide quality instruction (CACREP, 2009; CACREP, 2016), and CITs were surveyed as part of the program evaluation process for the university being represented in this research. The data were collected anonymously and published as part of the required counselor education program evaluation process mandated by CACREP, specifically that “program faculty members engage in continuous systematic program evaluation indicating how the mission, objectives, and student learning outcomes are measured and met” (CACREP, 2009, p. 7).

Participants

CITs who were invited to take the survey were in their final course sequence and would be graduating from their respective program within the next two months, at the latest, and were enrolled in an internship experience class. A total of 50 CITs qualified to complete the survey and, of the eligible CITs, 31 CITs completed the survey (62%). All of the CITs had successfully completed the core courses that are mandated by CACREP (2009, 2016), and the state licensure board for where the university is located. All CITs had completed classes in the following core areas: Professional Orientation and Ethical Practice, Social and Cultural Diversity, Human Growth and Development, Career Development, Helping Relationships, Group Work, Assessment, and Research and Program Evaluation.

Measurement

The survey that was administered consisted of 16 questions that focused on professional identity development, satisfaction of their counseling program including supervision, CITs' prospects of finding gainful employment after graduation, and any comments from the CITs about program improvement. Three questions were asked that specifically focused on responsibility and professional identification: “At what point in the program did you start to feel responsible for the well-being of your clients or future clients (Semester)”; “At what point in the program did you start to feel responsible for the well-being of your clients or future clients (Year)”; and “How would you rate your strength of identity as a Professional Counselor (i.e. School Counselor, Clinical Mental Health Counselor, Marriage, Family and Couples Counselor, etc.)?” Three open-ended questions were also asked of the CITs: “What did you find most useful in your program of study?”; “What did you find least useful in your study?”; and “What recommendations do you have for the Counselor Education Programs?” The first of these open-ended survey questions was most salient to this study. CITs completed the surveys on the SurveyGizmo platform which allows for the collection of data by way of electronic devices and has the option of not collecting identifying data. The data collected for the survey did not include identifying information and were password-protected through the program. The principle researcher was the only individual who had access to the raw data.

Results

We computed correlation coefficients among five counselor education satisfaction scales, one counseling professional identity scale, and a measurement of time when CITs started to feel responsible

for the well-being of their clients or future clients. Using the Bonferroni approach to control for Type I errors across the 21 correlations, a p value of less than .0024 ($.05/21 = .0024$) was required for significance. The results of the correlational analysis show that three out of the 21 correlations were statistically significant and were greater than or equal to (.58). The three significant correlations from the study included CITs feeling prepared to work with their professional population and the strength of the CIT's identity as a professional counselor ($r = .588, p < .001$); recommending the counselor education program to someone looking to become a counselor and practicum/internship experience preparing CITs to work with professional populations ($r = .589, p < .000$); and recommending the counselor education program to someone looking to become a counselor and the belief that quantity of teaching in the program is high ($r = .667, p < .000$).

If the Bonferroni approach to control for Type I errors across the 21 correlations was not used and the standard ($p < .05$) level of statistical significance was used, the results of the correlational analysis show that three more of the original 21 correlations were statistically significant, totaling six correlations which were greater than or equal to (.41). The three significant correlations from the study included the strength of the CIT's identity as a professional counselor and practicum/internship experience preparing CITs to work with professional populations ($r = .419, p < .019$); the belief that quality of teaching in the program is high and practicum/internship experience preparing CITs to work with professional populations ($r = .453, p < .010$); and overall I feel prepared to work with my professional population and the courses in the counselor education program helped in my professional position, ($r = .502, p < .004$).

Of the researchers' interest is the intersection of CITs' feeling responsible for the well-being of their clients and at what point this phenomenon occurs. The researchers surveyed the CITs and asked: *At what point in the program did you start to feel responsible for the well-being of your clients or future clients* (Table 1.1). 38.7% ($n = 12$) of the CITs responded that they started to feel responsible for the well-being of their clients as they began field experiences required by the counselor education program. Another 29% ($n = 9$) indicated that as they began the field experience, they started to feel responsible for the well-being of their clients. The total for CITs indicating the beginning of the field experience was when they started to feel responsible for the well-being of their clients was 67.7% ($n = 21$).

Table 1.1

At what point in the program did you start to feel responsible for the well-being of your clients or future clients?

Semester	Year	Percentage	Cumulative Percentage
Fall	Year 1	16.1%	16.1%
Spring	Year 2	3.2%	19.4%
Fall	Year 2	29%	48.4%
Spring	Year 3	38.7%	87.1%
Fall	Year 3	6.5%	93.5%
Spring	Year 4	3.2%	96.8%

Note: CITs have the option of starting their counseling program in the Fall or Spring semesters but can only start their practicum in Spring semesters and Internships in Fall semesters.

The open-ended aspect of this survey question (“What did you find most useful in your program of study?”) provided additional information, as follows: “Internship class; I found that our Internship class was extremely helpful in developing myself personally which leads me to be better professionally”; “Internship – hands-on experience and supervision”; “Listening to other classmates' experiences and seeing/hearing what they do in session with clients and getting to role-play”.

Discussion

The researchers hypothesized that CITs would feel the sense of responsibility once they have had the practice of actively engaging with clinical populations, which was indicated by the quantitative data. The three correlations that were statistically significant and of moderate to strong strength, while controlling for Type I errors, included quality of teaching and the correlation to recommend someone to the program, positive internship experience and recommending someone to the program, and the correlation of CITs feeling prepared to work with their chosen population and strength of professional identity. Of importance to this study is information generated by the open-ended aspect of the survey question which indicates that internship is an activity that helps to develop positive professional identity and the feeling of being prepared to work with others.

The data of when CITs began to feel responsible for their clinical populations (Table 1.1) indicated that practicum (Spring Year 3) was overwhelmingly identified (38.7%). The previous semester (Fall, Year 2), which is a semester when CITs are not enrolled in any clinical experience, was particularly high (27%). The researchers believe that the CITs were starting to feel the responsibility for clinical populations because it is around this time that the CITs are interviewing at clinical placements for their practicum and internship experiences. For the CITs in this study, they had a date of the 3rd Monday in October to have their clinical sites for practicum and internship secured. The researchers believe that this may be a point in the program where CITs are understanding that they will be working with people in a very short time. These two semesters are of importance to the researchers because the CITs of this program typically are at the end of their program and they are getting ready to start their field experience. This time accounts for more than 67% of the variance.

The researchers also hypothesized that CITs with perceived higher levels of satisfaction would be correlated with higher levels of professional identity. The data indicated that there was a moderate positive correlation between belief of a quality program and recommendation to the program along with the moderate positive correlation of CIT's internship experiences and their recommendation to the program. It can be concluded that there is a link between CITs who recommend the program and their belief that the program is of quality including their preparation to work with professional populations. Preparation for CITs to work with professional populations is moderately correlated to the CIT's identity as a professional counselor which is congruent with the literature that indicates that satisfaction with program resources and specifically with supervision has a direct link to the positive creation of professional identity (Shlomo, Levy, & Itzhaky, 2012).

Combined, the correlative and descriptive data appear to make a strong argument for our initial hypotheses. CITs appear to begin to assume responsibility as they begin to prepare in earnest for their practicum experience and, most significantly, when they entered the field in their practicum semester. Their open-ended responses endorsed the field experience itself and a crucial aspect of this experience, namely supervision. Given these results and given the developmental framework we have adopted in our study, the question remains, How can counselor educators intentionally structure their programs such that CITs arrive at the crucial time of field experience with adequate preparation to fully assume their professional responsibilities? Our results indicate that students experience a large bump in awareness of professional identity and responsibility when they begin to prepare to and then actually see clients, a

fairly obvious but important point for counselor educators to keep in mind to maintain high levels of CIT satisfaction and engagement. But it is equally obvious and important to understand that it is the responsibility of the counselor educator to hold a macro view of the development that needs to occur such that this particular phase can be fully accomplished. To that end, we offer the recommendations below.

Recommendations

Counselor educators should intentionally structure the entire educational experience to develop professional responsibility in CITs. The following are recommended activities that should take place throughout the training process.

- 1) Prior to admission, programs could introduce the idea of professional responsibility. Information on the role and responsibilities of a professional counselor could be prominently displayed on websites and promotional and application material.
- 2) Upon acceptance, a statement on the role and responsibilities of the professional could be included. CITs could be asked to attest that they realize that they are entering a profession with ethical and legal responsibilities.
- 3) At orientation, CITs could be given information on professional responsibility and asked to perform small group activities that help them to begin to assume an internal locus of responsibility.
- 4) Throughout the curriculum, lessons on responsibility could be integrated into coursework.
- 5) In micro-counseling/skills acquisition courses, CITs could be provided with role-play opportunities. Instruction could be geared toward helping them understand and process how this work is similar to and different from actual counseling and their responsibilities toward actual clients.
- 6) When CITs arrive at the midpoint of the CIT program, CITs will apply to be masters-level candidates and as a component of candidacy, they could be asked to reflect on their growing sense of professional responsibility.
- 7) At orientation meetings that occur prior to practicum and internship, CITs could be oriented to how they might develop the final piece of the professional responsibility puzzle in their clinical experience. For example, Koltz and Champe (2010) talk about how this development may take place (shaping/practicing/emerging), which could help to sensitize CITs to the topic and focus their attention on it prior to actually taking practicum and internship.
- 8) Prior to starting a search for a practicum/internship site, CITs could create a statement of readiness for practicum/internship, reflecting on their studies and how they have prepared themselves for the clinical experience, as well as creating a plan of self-care and time management which includes submitting a calendar created by the CIT detailing how the CITs plans on managing their professional time, school time, personal time, and self-care time throughout the clinical experience.
- 9) In practicum and internship coursework, the past experiences in coursework focusing on professional identity and responsibility could be reviewed and applied in case presentations.
- 10) Exit surveys could ask CITs at the end of their program of study to reflect on their development of professional responsibility, the strategy undertaken by this present study.
- 11) And finally, alumni can be contacted. Alumni can respond to surveys asking about their experience as new professionals and these results disseminated to current CITs. Additionally, invitations could be issued to alumni who could offer their perspective on the topic of professional responsibility to practicum and internship classes.

Limitations

While the review of the quantitative data used an approach to control for Type I errors in a smaller population, one of the largest limitations of the study was the survey sample. Ideally, the researchers would like to have had a much larger sample size that spanned across the entire educational

program, was sampled from several universities, and included students in counseling-related disciplines. Had these parameters been met, the researchers would have been able to make more global statements about the data collected, had it been congruent with the findings of this research.

Conclusion

Our results indicate that there is a correlation between a CIT's sense of professional responsibility and when the CIT is actively engaged in practical experiential activities. While the topic of how to teach responsibility in professional counseling is left up to individual programs, counselor educators have the responsibility to help CITs develop a sense of responsibility that will bring forth effective and ethical practices within the profession. The developmental approach that we reference provides a lens to understand how CITs begin to assume responsibility for their clients, and the recommendations we provide can help counselor education programs to intentionally facilitate this crucial process. Counselor educators must remain mindful that while they can and must assume responsibility for CITs and the clients that the CITs serve, this is only part of the process. Ultimately, the CIT must locate responsibility within themselves and determine to act on it, in order to become a fully functioning and ethically responsible counselor.

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Feedback-Informed-Treatment: A Deliberate Approach to Responsible Practice

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Abstract

As research continues to proliferate about the effectiveness of psychotherapy, mental health clinicians appear to be limited in their effectiveness and growth. If clinicians hope to meet their ethical responsibilities of beneficence and accountability, new methods to ensure client success are needed. Within the framework of deliberate practice, clinicians can use the methods of Feedback-informed treatment (FIT) to effectively modify treatment and improve their own performance, resulting in improved client outcomes. This manuscript will provide the evidence supporting the use of deliberate practice and FIT, the major aspects of each, and the potential that these approaches offer to mental health clinicians to meet their ethical responsibilities to meet client needs through effective and empirically supported methods.

Keywords: Deliberate Practice, Expertise, Feedback-Informed-Treatment, Evidence-Based Practices, Clinical Outcomes

Feedback-Informed-Treatment: A Deliberate Approach to Responsible Practice

Mental health professionals are in a difficult position in modern healthcare. The overall effectiveness of mental health treatment has been established in laboratory and real-world settings, where most clients show reliable improvement when compared with non-clients (Wampold & Imel, 2015).¹ At the same time, researchers continue to find little quality improvement compared to previous decades; for psychotherapy as a treatment and individual clinicians, there is no demonstration that clients are receiving better care than they were in the 1980s. Researchers and clinicians are thus presented with an intriguing problem: psychotherapy appears to be both effective but also resistant to improvement.

For many years, researchers of psychotherapeutic effectiveness asked what seemed to be an obvious and important question, “Which theoretical treatment approach works best?” However, researchers have consistently found that client outcomes often have little to do with the treatment approach a clinician uses. Instead, the common factors of psychotherapy (Frank & Frank, 1991) that emphasize clinician factors like warmth, empathy, collaboration, and flexibility have a stronger relationship to client outcomes than any particular approach (Wampold & Imel, 2015). In order to provide effective care, some researchers are now urging clinicians to gather data from clients to measure and track how clients are improving each session (Maeschalck & Barfknecht, 2017; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Miller, Hubble, Chow, & Seidel, 2013). By formally gathering feedback about clients’ outcomes in psychotherapy, these authors show how to monitor client progress, modify treatment in real time, and achieve better outcomes for clients.

In this article, I will argue that mental health clinicians have a responsibility to their clients and the public to utilize the available tools based on client outcomes. I will begin with a brief description of the limitations of psychotherapy’s current approach and posit deliberate practice and feedback-informed-treatment as potential solutions. Finally, I will conclude with a description of the implications current evidence has for the mental health professions.

Psychotherapy’s Problem: Effectiveness without Improvement

Since the late 1970s, the data on the effectiveness of psychotherapy has been clear. Overall, psychotherapy is effective for helping a wide range of people recover from a wide range of problems (Miller et al., 2013; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Wampold & Imel, 2015). Researchers also continue to find support for the Dodo Bird Hypothesis (Rosenzweig, 1936), which suggests there is no difference among genuine psychotherapeutic treatments (Wampold et al., 1997). Despite the emphasis on cognitive-behavioral therapies in the literature, the evidence suggests that all treatments are similarly effective. This finding holds true even when “therapeutic” components are removed (Frost, Laska, & Wampold, 2014). Because of psychotherapy, people who seek treatment are better off following treatment than 80% of those who do not.

However, in their discussion of the evidence for psychotherapy, Wampold and Imel (2015) argue that despite consistent outcomes, effectiveness has not improved. In fact, there has been little improvement in the field over the last few decades when considering client outcomes (Rousmaniere, Goodyear, Miller, & Wampold, 2017a). Current estimates of effectiveness are roughly similar to Smith and Glass’s findings in 1977. New treatment approaches and modalities have been introduced, but as these all roughly maintain the equivalent effectiveness (Wampold & Imel, 2015).

One avenue for improvement is to examine ways to improve the effectiveness of clinicians in their training, supervision, and ongoing professional development in clinical practice. Significant efforts have been undertaken to provide comprehensive education to incoming professionals, and competency

¹ Researchers have differentiated between “efficacy,” or laboratory results, and “effectiveness,” or real-world results (Wampold & Imel, 2015); the focus in this article is on the clinical application of deliberate practice and FIT in mental health settings, or its effectiveness.

movements have focused on improving training (Fouad et al., 2009; Hatcher et al., 2013) by establishing the important behaviors of clinicians and developing professionals as guidelines. Other professions have implemented comprehensive minimum standards for graduate programs (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015) which address the areas in which clinicians should be knowledgeable.

Psychotherapy researchers, however, have called into question the utility of graduate school training for mental health clinicians. While performance expectations are high for students within graduate programs, these efforts have had limited effect on clinicians-in-training's skills (Erekson, Janis, Bailey, Cattani, & Pedersen, 2017; Owen, Wampold, Kopta, Rousmaniere, & Miller, 2016), and when comparing client outcomes from the beginning and end of clinicians' training, there appears to be limited growth in the skill level of graduate student clinicians (Erekson et al., 2017). The process of training to be a mental health clinician also appears to have a limited effect on clinicians-in-training's ability to work with clients with more severe distress (Owen et al., 2016). And supervision, the mental health professions' signature pedagogy (Bernard & Goodyear, 2019), also has little effect on clinicians-in-training's effectiveness (Owen et al., 2016; Rousmaniere, Swift, Babins-Wagner, Whipple, & Berzins, 2016; Watkins, 2011). In effect, graduate training does not seem to contribute to clinicians' ability to aid clients in improving their wellbeing.

The story does not appear to improve as clinicians are followed into their post-graduate careers. Following graduate school, licensed and practicing clinicians appear to peak early in their careers and proceed to worsen in effectiveness as time goes on (Goldberg et al., 2016; Miller et al., 2013). Clinicians are required by licensure bodies to complete continuing education credits, but these educational courses also do not appear to have an effect on treatment quality (Taylor & Neimeyer, 2017). Practicing clinicians are also generally poor assessors of their own ability (Chow, 2017; Walfish, McAlister, O'Donnell, & Lambert, 2012) and of their clients' wellbeing or risk of deterioration (Hannan et al., 2005). The average clinician appears to have significant difficulty when it comes to moving beyond average performance, and often are no more effective than graduate students (Christensen & Jacobson, 1994; Lambert, 2013).

A Solution to the Problem

A solution may lie not in what makes an "average" clinician effective, but in what makes some clinicians more effective than others, how client outcomes can help differentiate between high-performing and low-performing clinicians, and how individual clinicians can systematically use client feedback to improve their performance. The rise of common factors models (Frank & Frank, 1991; Kiesler, 1966; Wampold & Imel, 2015) and the increased attention to clinician factors (Ackerman & Hilsenroth, 2001, 2003; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Crits-Christoph et al., 1991) have brought greater attention to the differences between individual clinicians. When clinicians are more capable of expressing empathy, genuineness, and positive regard (Elliott, Bohart, Watson, & Greenberg, 2011; Farber & Doolin, 2011; Kolden, Klein, Wang, & Austin, 2011) and collaborating with their clients (Tryon & Winograd, 2011), they are capable of building stronger relationships with client. When clients and clinicians have better relationships, clients achieve better outcomes.

The skill of the clinician significantly contributes to the relationship between clinician and client. Anderson and colleagues (2009) asserted that tests of these skills were predictive of therapeutic relationships and client outcomes in the future. Research like this has led some authors to argue that clinicians bear the responsibility for the quality of the relationship (Wampold, 2017; Wampold & Imel, 2015). Therapeutic relationship skills, like building the working alliance (Bordin, 1979) have been shown to be sensitive to instruction and practice (Connor & Leahy, 2016). With the advances to our understanding of therapist effects and the importance of common factors, some authors are beginning to see the possibility of clinicians improving their ability to help clients, and the deliberate practice framework provides a potential way forward for mental health clinicians and professions.

Deliberate Practice

The deliberate practice framework was described by Ericsson and Lehmann (1996) and brought into the popular consciousness by Malcolm Gladwell (2008). Deliberate practice, as the name suggests is an intentional, *deliberate* approach to skill development. Ericsson and Lehmann (1996) define deliberate practice as “individualized training activities especially designed by a coach or teacher to improve specific aspects of an individual’s performance through repetition and successive refinement” (pp. 278-279). Put simply, deliberate practice is the idea that individuals improve in a given area when they are motivated to maintain focus and attention on a task, repetitively practice this task under the guidance of a more expert teacher, and modify, refine and improve their performance based upon feedback they have received. Ericsson and colleagues’ model of expertise development is a series of concentrated practices of discrete skills that slowly approach expert performance, and their model has been applied in a wide range of fields including music (Ericsson, Krampe, & Tesch-Römer, 1993; Platz, Kopiez, Lehmann, & Wolf, 2014), sports (Baker & Young, 2014), and medicine (Ericsson, 2004; Ericsson, 2015).

While researchers have demonstrated skill development in music, games, or sports with deliberate practice, the fields of medicine and medical education may provide a better comparison for the mental health fields. Medicine and medical education are similar to mental health disciplines because they require complex decision-making, fine-tuned skills, and efficient action under pressure. McGaghie (2017) describes the integration of deliberate practice and a similar practice in mastery learning into medical education. He describes the necessity of the field of medical education to improve beyond “see one, do one” which has dominated the field for nearly a century in order to effectively address patient needs and improve patient outcomes. The mental health professions find themselves in a similar position.

While the efforts to implement deliberate practice in the training of mental health clinicians has been limited, there are some efforts taking place. In the first study of its kind, Chow and colleagues (2015) were able to demonstrate that the most effective clinicians spent more solo time outside of sessions practicing, developing their skills as clinicians, and learning. Much like earlier studies in other fields, the top performing clinicians spent almost three times as long practicing each week as the bottom three quartiles. While only an initial exploration of psychotherapeutic deliberate practice, these results suggest that this process is applicable in the mental health professions.

Other researchers have begun to integrate deliberate practice into counseling. Miller, Hubble, and Chow (2017) distilled deliberate practice into four major elements, which include a sustained practice focused on improving performance, the guidance of a teacher or mentor, regular and timely feedback, and refinement through repetitive solo practice. Goodyear and Rousmaniere (2017) describe a similar process. Motivated individuals set baseline levels of performance, and as they practice or perform, they gather feedback about their performance that is timely and specific. With the help of a coach or mentor, they set distinct, incremental goals with clear steps. The coach or mentor—or in the case of counseling, the clinical supervisor or consultant—helps individuals refine practice, develop new strategies, and identify limitations. This iterative process feeds back into itself. Clinicians continue to develop new baselines that informs future practice to develop new baselines. The process of developing expertise through deliberate practice is intensive but produces results.

Feedback-Informed-Treatment

Feedback-informed-treatment (FIT), a counseling approach that involves the practice of systematically collecting feedback from clients about their progress on a regular basis, tracking their responses, and incorporating this feedback about their progress and the relationship into treatment (Maeschalck & Barfknecht, 2017), follows the established principles of deliberate practice. More than just asking each client how they feel their treatment is progressing, FIT uses validated measures to analyze patterns and find weak areas in clients’ overall wellbeing or in the working alliance. FIT is not only the gathering

and tracking of this data, though; mental health clinicians have the responsibility to incorporate this data into their work with clients.

The process of gathering and analyzing data from clients is a step in the right direction to address some of the shortcomings of mental health care. Previous researchers have argued that mental health clinicians struggle to assess their work accurately, and FIT can help clinicians to discharge their responsibility to provide more effective care for their clients. Rather than asking clinicians to make often erroneous assumptions about clients, FIT requires clinicians to directly gather data from clients on their progress or deterioration in treatment. I now examine in more detail the component elements of FIT: Gathering feedback data directly from clients, analyzing feedback data for areas for improvement, and implementing the feedback into treatment (Prescott, 2017).

Gathering Feedback

For FIT to work, feedback must be gathered systematically. While many mental health clinicians may feel like they already informally ask their clients how their treatment is progressing, informal data gathering does not appear to provide any consistent data on which clinicians can act (Prescott, 2017). This aspect is like setting baselines in the deliberate practice framework. Without a baseline and without this feedback, there are no benchmarks with which to compare client or clinician growth. When clinicians do not gather feedback data from clients, their ability to be effective with a wider range of clients is limited.

Some mental health clinicians have demonstrated a reluctance to gather feedback about their work with clients (Gilbody, House, & Sheldon, 2002; Zimmerman & McGlinchey, 2008). Prescott (2017) suggested that this reluctance stems from a few factors, including clinicians' beliefs that gathering feedback could coerce clients' responses, perceptions of conflict with the treatment approach or modality, and fears about slowing down the progress of treatment. Other suggestions include the belief that clients should be responsible for providing feedback to clinicians. Some clinicians may even believe they are already soliciting feedback and do not need to formalize their process. These positions have little to no support in the available literature or evidence-based practice.

Tools to Gather Feedback. In order to gather useful data, clinicians and researchers have developed a variety of measures. While there are many different, valid methods to collect data from clients, two major systems are the Outcome Questionnaire-45 (OQ-45; Lambert, 2012) and the Partners for Change Outcome Management System (PCOMS; Duncan et al., 2003; Duncan, Miller, Wampold, & Hubble, 2010; Miller & Duncan, 2006; Miller, Duncan, Brown, Sparks, & Claud, 2003).

The OQ-45 is an assessment tool that asks clients a variety of questions about overall wellbeing, relationship functioning, and symptomology (Lambert, 2015). It consists of 45 questions and takes up to 10 minutes to complete; clients fill it out at the beginning of every session (Lambert, 2012). The OQ-Analyst system is a system that enables mental health clinicians to gather this data and review it quickly. Once the clinician has reviewed the results, they and client are able to use the results to guide the session based on the areas that clients identify on the measure. The OQ-45 is built to categorize clients as "recovered", "improved", "unchanged", or "deteriorated" based on comparing current and previous scores (Lambert, 2015).

In response to the OQ-45's length and the time it takes to implement, another group of researchers developed the Partners for Change Outcome Management System (PCOMS). The PCOMS is actually two measures, the Outcome Rating Scale (ORS; Miller et al., 2003) and the Session Rating Scale (SRS; Duncan et al., 2003). Much like the OQ-45, both can be used every session—the ORS used at the beginning of the session to monitor client wellbeing and the SRS used at the end to monitor the working alliance. The PCOMS measures are unique because they use Visual Analogue Scales rather than Likert-type or numbered scales. These scales are marked at the appropriate point along a line, and the mental health clinician will measure the distance from the left side to generate a score. Due to their

ease of use, the ORS and the SRS are more commonly used by current FIT-practicing mental health clinicians (Maeschalck & Barfknecht, 2017).

While the OQ-45 and PCOMS are the most common FIT measures, there are additional methods of data collection. Chapman and colleagues (2017) detailed five other quantitative measures, while McLeod (2017) discussed the use of qualitative means to assess client outcomes and the working alliance. None of the available measures is perfect, but they provide a structured, formal assessment of client progress in every session.

Analyzing Feedback

Analyzing feedback from clients helps clinicians further set a baseline level of performance. Not only can clinicians develop an understanding of their average performance, gathering and analyzing data from each client can help identify areas for growth regarding certain client presentations, diagnoses, populations, or modalities. Casting a broad net for feedback allows clinicians to find their strengths and limitations, set realistic goals, and reinforce the effective practice they already have. Feedback can clue clinicians into general trends and help spot red flags that indicate premature termination or the need to modify treatment.

Premature termination is the discontinuation of treatment before reaching client goals or termination that the mental health clinicians was not anticipating (Anderson, Tambling, Yorgason, & Rackham, 2019). Swift and Greenberg's (2012) meta-analysis suggests roughly one in five clients will prematurely terminate treatment. The role that mental health clinicians have in premature termination appear equal to the role that they have in successful treatment outcomes (Anderson et al., 2019; Zimmermann, Rubel, Page, & Lutz, 2017). By monitoring client outcomes and the quality of the working alliance from the very first session, clinicians can address clients' concerns immediately (Goodyear & Rousmaniere, 2017; Maeschalck & Barfknecht, 2017). Miller, Duncan, Brown, Sorrell, and Chalk (2006) demonstrated that the use of feedback to address premature termination resulted in an increase in retention.

An advantage to using formal, standardized assessments is that available research can help make sense of clients' ratings and plan for effective intervention. For example, Bertolino and Miller (2013, as cited in Maeschalck & Barfknecht, 2017) identify "bleeding", "dipping", "fluctuating", and "plateauing" as possible patterns, and offer suggestions for tailoring treatment approaches under these circumstances. These patterns, which include slowly decreasing outcomes scores, sudden dips in scores, rapid increases and decreases in scores, and scores that seem to "stall" can be an indicator that mental health clinicians need to change their strategy. When not gathering feedback, clinicians struggle to see these patterns.

Implementing Feedback

In deliberate practice, practitioners use their baseline performance to set goals and develop incremental steps to reach them. Similarly, using the data to identify areas for improvement involves using the data to set a reasonable goal, adjusting work with clients, and attempting to meet client needs more effectively. There are varieties of ways clinicians can implement their data back into their work, and their choice depends on the available evidence and the needs of their clients.

Once feedback data is gathered, clinicians have several choices for how to use the data. Clinicians can use this data to monitor, guide, or influence the course or treatment. Sharing feedback with clients and using it as initial talking points for can be useful. Individual data points can help begin or end sessions, or data trends can be used to help bridge between sessions or consolidate treatment progress. Finally, clinicians can aggregate the feedback from all their clients to facilitate their own improvement or supervision.

When mental health clinicians track clients' outcomes, they can track when clients might not be progressing as expected and can adjust their course. Maeschalck and Barfknecht (2017) suggested that

when clients' ratings appear to plateau or worsen, it might be necessary to change the provided treatment, increase session frequency, or modify the intensity of treatment. They further suggested that if little to no change results from these modifications to treatment, clients' scores could aid in considering the need for referral or termination.

The Evidence for Feedback

The mental health professions have a history of providing treatments that are discredited, ineffective, or even harmful (Norcross, Koocher, & Garofalo, 2006). Some ill-conceived practices have been dangerous enough that they resulted in clients' deaths during or following treatment (Mercer, 2001; Serovich et al., 2008). While the evidence supporting deliberate practice in mental health care is limited, FIT has a solid evidence base. This evidence base supports both clinicians and clients having access to their own feedback data and the use of FIT in the treatment of specific disorders.

In some studies about FIT, sharing feedback from clients progress to clinicians can double the effectiveness of treatment (Lambert et al., 2003; Miller et al., 2006; Simon, Lambert, Harris, Busath, & Vazquez, 2012; Whipple et al., 2003). Meta-analyses have suggested that FIT generally results in improved treatment outcomes (Lambert & Shimokawa, 2011; Lambert, Whipple, & Kleinstäuber, 2018; Østergård, Randa, & Hougaard, 2018). In others, while statistical significance was limited, effect size data suggests clinically significant effects of feedback (Hansson, Rundberg, Österling, Öjehagen, & Berglund, 2013; Newnham, Hooke, & Page, 2010; Probst et al., 2013; Shechtman & Tutian, 2017).

Not only is gathering and using feedback useful for mental health clinicians, the evidence suggests that the benefit increases when clinicians share feedback data with clients. When clients are more actively involved in implementing the feedback they provide, they are often more comfortable with the process (Börjesson & Boström, 2019). Clients being involved with FIT have also been shown to have benefits when compared to both treatment without feedback and FIT in which only the clinician has access to the data (Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Whipple et al., 2003). Tilsen and McNamee (2015) have suggested gathering feedback encourages clients to engage in their treatment with greater self-reflection. This reflexive engagement might explain how this feedback seems to improve client outcomes, lead clients to engage more with the specifics of the treatment and help them feel more connected to their mental health clinician.

Researchers investing the use of FIT in the treatment of specific disorders have found promising results. Crits-Christoph and colleagues (2012) found that the use of client feedback had positive effects in the treatment of alcohol and substance use disorders. Others have shown that outcome feedback served to reduce self-harm behaviors associated with disordered eating (Schmidt et al., 2006). In a large-scale study of low-income clients with depression, the use of FIT was associated benefits greater than treatment without it (Reese, Duncan, Bohanske, Owen, & Minami, 2014). When used with patients identified as highly distressed, FIT did not improve outcomes, but its use was associated with an improvement in the therapeutic relationship (Tzur Bitan et al., 2019). These studies support the use of FIT across modalities and disorders.

The mechanism through which feedback is effective is still a subject of investigation (Wampold, 2015). There have been suggestions that FIT improves performance by allowing session-by-session adjustment of the working alliance (Brattland et al., 2019; Miller, Hubble, Duncan, & Wampold, 2010). Sapyta, Riemer, and Bickman (2005) speculate that when mental health clinicians receive feedback that indicates below-expectation performance, they experience motivation to modify their approach. Because FIT and deliberate practice share many processes, FIT may increase the amount of solo practice in which clinicians engage. Chow and colleagues' (2015) argue that this solo time is the strongest predictor of improvement.

There is evidence that the use of FIT may be ineffective or contraindicated in some settings and/or with certain individuals. FIT may not be indicated in some inpatient or emergency psychiatric settings.

When clients have experienced previous psychiatric hospitalization or were otherwise experiencing more severe symptoms, feedback about continued high symptomology was harmful (Errázuriz & Zilcha-Mano, 2018). When used with inpatient and day-treatment patients with personality disorder diagnoses, FIT appeared to be either ineffective, or harmful to treatment (de Jong, Segaar, Ingenhoven, van Busschbach, & Timman, 2018). In an emergency psychiatric setting van Oenen and colleagues (2016) found that clients in the feedback condition improved more slowly than clients receiving treatment as usual. Finally, while Østergård and colleagues' meta-analysis (2018) found a positive effect on treatment in outpatient populations, there was no benefit to the use of FIT with inpatient clients.

Overall, the use of FIT appears to improve treatment in a wide variety of settings. When paired with deliberate practice, the possibilities for further improvement appear significant. The evidence for both approaches affirms the need for further inquiry into the possibilities of education and professional development.

Integration of FIT and Deliberate Practice

Feedback-informed-treatment alone has great utility but does not seem to be enough to improve clinical practice. While FIT provides useful data for mental health clinicians, it is not necessarily associated with client improvement (Chow, 2017). Using FIT can help identify clients at risk of deterioration and problems associated with the therapeutic alliance, but it alone cannot produce better clinicians. The broader framework of deliberate practice for mental health clinicians holds unique promise that some prominent researchers have begun to investigate (Chow, 2017; Chow et al., 2015; Miller, Hubble, Chow, & Seidel, 2015; Rousmaniere, 2017, 2019; Rousmaniere, Goodyear, Miller, & Wampold, 2017). Future steps include steps taken by practicing clinicians to engage in continuing education opportunities to learn about deliberate practice and FIT and to use them in their daily practice, development of supervision and educational approaches that emphasize deliberate practice and FIT, and integrating deliberate practice and FIT principles into graduate education programs.

Many mental health clinicians remain resistant to adopting the framework of deliberate practice and incorporating FIT into their clinical work, and there is significant room for these practices to grow. Clinicians have a responsibility to the public to present their work accurately. If more clinicians adopted these practices and shared their outcomes with the public, it would allow clients and potential clients to evaluate their treatment providers. The clear benefit for clients is being able to choose a provider based on more than word of mouth or insurance referral. From the standpoint of clinicians as advocates for their clients, these changes are necessary.

There have been a few models described to implement deliberate practice and FIT into supervision. Bargmann (2017) describes a process to incorporate client feedback into supervision case presentations. Bargmann's FIT supervision process is brief, but her goal was delineating specific steps to increase effectiveness of supervision and clinicians. Other authors have developed complex models of supervision that incorporate FIT. The Expertise-Developmental Model (EDM; Rousmaniere, Goodyear, Miller, & Wampold, 2017) is based on the integration of deliberate practice with current supervision models. Supervisors using EDM have supervisees collect client feedback to establish a baseline, provide feedback based on video review of supervisees' work, and work with supervisees to develop practice routines that enable them to improve their skills, and thus improve their clients' outcomes. Due to their recent development, there is still limited research evidence for the effectiveness of EDM or other supervision models that use deliberate practice or FIT.

The integration of deliberate practice into graduate school curriculum would have a significant impact on the training process. The evidence of the effectiveness of graduate training programs is limited, and results suggest little improvement in clinician skills as a result (Erekson et al., 2017; Owen et al., 2016). While most graduate programs teach students helping and relationship building skills, the methods have come under criticism (Ridley, Kelly, & Mollen, 2011; Ridley, Mollen, & Kelly, 2011). By integrating deliberate practice into these courses alone, graduate programs could provide clinicians-in-

training with a more effective set of skills from the outset. New professionals better equipped with deliberate practice skills may be able to maintain or improve on their skill compared to their peers. When considering effective curriculum design, helping clinicians-in-training develop an appreciation for these practices and the potential they hold could help them integrate them into a lifelong process of learning and growth (Fink, 2013).

Medical education may provide a model for integrating the principles of deliberate practice into graduate programs. Using deliberate practice, mastery learning, and simulated scenarios have led to greater variation in educational experiences and the ability to target discrete skills that need practice (Ericsson, 2015; McGaghie, 2017). Using medical simulations, medical students can engage in role-plays with peers and standardized patients, practice difficult skills, and receive immediate feedback on their performance without potential harm to real patients (Diederich et al., 2019; Welsher et al., 2017). These practices have begun to be used in some mental health professions (Logie, Bogo, Regehr, & Regehr, 2013; Neuderth et al., 2019). Greater adoption of these practices could lead to more effective training methods.

There are practical barriers to adopting deliberate practice and FIT in clinical settings. Deliberate practice and FIT require greater clinician attention to each case, which takes time and energy, and there may be pushback from mental health care administrators. However, these practices can be defended on practical terms. Insurers often require documentation of client progress for reimbursement purposes, and the assessment instruments associated with FIT proved exactly this kind of documentation. Additionally, the argument can be made that using FIT could result in increased client engagement, less premature termination, and higher and more consistent rates of client attendance, indicates that would appeal to clinical supervisors and administrators. In systems where clinicians are constantly under pressure to see more clients and provide more documentation, it is the task of individual clinicians to make the practical and theoretical case for deliberate practice and FIT.

Conclusion

The mental health professions have been undergoing change for decades without much observable improvement in client outcomes. Deliberate practice and FIT hold real promise for improving client outcomes by enabling clients and clinicians to communicate more effectively about the progress of treatment. Deliberate practice provides a framework for the development of expert performance, and FIT fills out this framework, providing mental health clinicians with clear instructions about how to set baselines and monitor client progression or regression by systematically gathering, analyzing, and implementing client feedback. As the evidence for these approaches becomes more established, it is the responsibility of clinicians to take up these effective practices, the responsibility of graduate programs to improve their processes and train more effective graduates, and the responsibility of professional organizations to set new expectations for training and practice.

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Concluding Remarks: Responsibility and Therapeutic Freedom

Fred Redekop and Chad Luke

As we have seen from the foregoing articles, counselors and psychotherapists and those who train aspiring clinicians appear to readily acknowledge and assume the mantle of responsibility. Clinicians are responsible to make sure not that counseling begins, and, crucially, ends well (Schnyders and Bruns, 2020), and throughout the therapeutic process they are responsible to stay abreast of research findings on the process and outcome of counseling, perhaps the most crucial of which is the use of client feedback to enhance clinician performance and clinical outcomes (Budesá, 2020). Educators are responsible to help students develop a deeply felt responsibility toward their future clients (Bowers & Hamlet, 2020) and to gatekeep as both a remedial activity and, failing a successful outcome, a way to remove students who are not able to meet standards set by the profession (Kimball, Phillips, Kirk, & Harrichand, 2020).

And for perhaps most in the field, their responsibility doesn't end with individual clients and students, but rather extends toward society in general. Social justice is a component of many codes of ethics, and these codes enjoin members of the various disciplines to consider the impact of pernicious "isms" (racism, sexism, classism, ageism, heterosexism, etc.) on the mental health of clients and to take action to be an ally, as Evans, Williams, Staton, Green, and Shepard (2020) urge. In our conclusion to this special issue, we would like to suggest an organizing principle for a discussion of responsibility in mental health counseling practice and training: that there exists a continuum, with responsibility on one end and something we might call therapeutic space or therapeutic maneuverability on the other. In an interesting way in both theory and clinical practice, any increase in therapeutic responsibility can be seen as decreasing the amount of therapeutic space, and counseling ethics may be seen as the way to balance the two in order to find some kind of acceptable middle ground.

"Therapeutic Space" may seem to be a bit of a New Age term, but it can be seen as what is implied in Freud's (1913/2002) foundational requirement: "You should say everything that comes in to your head" (p. 56), something that later analysts such as Spotnitz (1976; Sheftel, 1991) emphasized: *you must say everything*. In saying everything, clients come to the insight that what seemed to prevent their movement toward growth and cure may in fact be illusory. In recognizing the self-imposed linguistic confines in which they have placed themselves, Freud's patients could recognize that they may in fact be free to move in a newly created therapeutic space.

But this is too simple. Are there no impediments to one's newfound freedom? Are there to be no consequences? Freud gave license to speak of societally forbidden topics such as sex. However, even as Freud granted permission, he hedged it with the labyrinth of interpretation, and the bewildered patient had to take Freud's hand as he led them, via his interpretations, out of the maze. Freud's concept of therapeutic space may be seen as severely circumscribed by what he saw as an unfortunate yet implacable truth about the human condition: we are in thrall to the master of repressed sexuality, and he saw it as his responsibility to convey this to his patients. Jung protested the implications of this position to Freud, but Freud didn't appear to be fazed: when Jung (1961) said that "culture would then appear as a mere farce, a morbid consequence of repressed sexuality," Freud responded, "so it is, and that is just a curse of fate against which we are powerless to contend" (p. 150). Freud, even as he encouraged freedom of expression, felt responsible to remind his patients that while they might become more aware of their motivations and drives, this entailed a stoic recognition of their (powerless) condition. The best he could offer them was limited, that of transforming "hysterical misery into ordinary unhappiness" (Breuer & Freud, 1893–1895/1955, p. 308). Thus, even at the beginning, the clinician might be seen as responsible to simultaneously free the client and remind them of limitations to this freedom due to the human condition, struggling to find some middle path forward between the poles of responsibility and freedom.

The prescription, say everything, was carried forward in an interesting way in the work of Carl Rogers. Though Rogers often used Freud as a foil and objected to psychoanalysis for various reasons, such as his view that it was impractical, too focused on past rather than present experience, fanciful in its interpretations, and was seemingly unconcerned with empirical research, he did acknowledge the influence Otto Rank's more relational views of psychotherapy on his own theory (Kirschenbaum, 2009). What is perhaps less immediately clear is the degree to which his nondirective/client-centered/person-centered approach is aimed at facilitating an atmosphere for the client to follow Freud's dictum to say everything. Rogers (1959) used the term, *conditions of worth*, to describe the process which arises "when the positive regard of a significant other is conditional, when the individual feels that in some respects he is prized and in others not" (p. 209). And in a fascinating section, Rogers (1959) describes the impact of caregivers on the developing infant and child and how the child learns to reject some parts of their own experience because of disapproval from the caregiver, which sounds a lot like Freud's views on how repression is formed, albeit in different terms.

Rogers' healing prescription was, in essence, a restatement of Freud's. The unconditional positive regard of the therapist allows the client to speak about their own experience and come to prize it; the "unconditional" aspect only makes sense when one realizes that the healing space directly counters the conditions of worth that was experienced by the client. And the responsibility of the therapist? Rogers continually stressed that a large part of the therapist's work was to provide a space where the client could speak and the therapist would listen empathically; that is, it was the therapist's responsibility to create the space and then to get out and stay out of the client's way as the client discussed their experience and what they wanted to do with it. Ideally, the therapist made no demands, issued no directions, other than that the client should begin to trust their own judgment. Rogers (1949), in writing about the type of perspective that a therapist should take, emphasized that "only as the therapist is completely willing that *any* outcome, any direction, may be chosen—only then does he realize the vital strength of the capacity and potentiality of the individual for constructive action" (p. 94).

But this grand restatement—Therapy is a place where the client may proclaim any direction and path for their life—hit an immediate snag. As Kirschenbaum (2004) relates, participants in training workshops were quite happy to point out a central tension inherent in this nondirectivity and to satirize it for him in skits at the end of the training:

"Dr. Rogers," the client would say, "I'm feeling suicidal."

"You're feeling suicidal?" Rogers would answer.

"Yes, I'm walking over to the window, Dr. Rogers."

"I see. You're walking over to the window," Rogers answers.

"Look, Dr. Rogers, I'm opening the window," the client says.

"You feel like opening the window?" Rogers reflects.

"Yes, I'm putting one foot out of the window, now."

"You're halfway out, is that it?"

"Yes, now I'm jumping Dr. Rogers"

"Uh, huh, uh, huh, you're jumping," says Rogers.

And, sure enough the client jumps, making a whooshing sound as he falls through the air before landing with a crash.

Thereupon Rogers walks over to the window, looks out and reflects, “Whooooosh . . . Plop!” (p. 119).

Rogers protested against this oversimplification, but the question remains: Is he saying that the counselor should just sit there, or does the counselor need to get up and shut and lock the window to prevent the client from jumping? Once again, the struggle is to find some middle ground between jumping up and taking action the moment a client says something even remotely suggesting suicide and sitting there passively even as they jump out the window.

As Strickland, Luke, and Redekop (2020) make clear in their article on coercion in mental health crises, a decision has been reached that there are limits to a therapeutic encounter: the window must be closed. In cases involving the active threat of suicide or homicide, and in cases involving child abuse and neglect, the field has seen and often participated in, willingly or not, the growth of legislation governing these cases. With the rise in mental institutions, there was a concomitant rise in involuntary commitment statutes by states over time and court action to address commitment in a substantial way, and a need for later revisions to commitment to focus on the key element of threat of harm to self (Myers, 1984), the assessment of which is in the domain of the clinician responsible for the treatment of the client.

Correspondingly, the landmark case of *Tarasoff v. The Regents of the University of California* set in motion legislation that ultimately defined the responsibility of clinicians when the client threatens others, albeit legislation that varies by state (Herbert & Young, 2002). This large variation can cause confusion to clinicians—some states mandate a clearly articulated duty to warn or duty to protect (through warning or other means) while others don’t, and even in those states with what appeared to be a settled understanding, revisions continue to occur. In Pennsylvania for example, in *Emerich V. Philadelphia Center for Human Development, Inc.*, the Pennsylvania Supreme Court found that a mental health professional has a duty to warn if their client or patient presents a serious danger of imminent danger to an identifiable third party (Fliszar, 2000); in so doing, “he or she must now must balance the competing interests of breaking patient confidentiality and its often negative impact on the therapeutic process with public safety and the possibility of liability” (p.212).

While this case provided some guidance and was for a time the standard for Pennsylvania clinicians—that a duty to protect through warning exists if the threat targets an identifiable third part—a recent court finding shrank the therapeutic space still more. In *Maas v. UPMC Presbyterian Shadyside* (2018), the Superior Court of Pennsylvania examined the case of Mr. Andrews who “expressly communicated threats to kill his ‘neighbor, but did not identify, by name or description, the specific neighbor” (para. 1148). While the threat was not directed at a specific individual, the Court found that since the threat was limited to “the fourth floor tenants of Hampshire Hall who were Mr. Andrews’s neighbors,” whom the Court described as “a small, distinct, and identifiable group” (para 1148), then the defendants had a duty to warn the entire fourth floor of approximately twenty people. This ruling raises the specter of the clinician phoning entire floors of buildings, perhaps whole offices and schools, whenever a client makes a threat, something that may cause clinicians to feel that these court cases have painted the entire floor with liability and left clinicians trapped in the corner.

The requirements for the reporting of child abuse similarly saw an increase in legislation over time, and by 1967, all states had child abuse reporting laws (Myers, 2008); the system worked so well that the less-than-fully-staffed agencies responsible became overwhelmed with calls, a problem that persists to this day (e.g., DePasquale, 2017). These duties taken together, and without mentioning other duties that are in the process of expanding state-by-state (such as the mandatory reporting of elder abuse) suggest that the field has come a far distance from the original requirement of say everything. Or, more precisely, the client can still say everything, but there may be increasing consequences, such as the reporting of what the client says to authorities or the initiation of civil commitment of the client. Students who are being trained in the work are given two messages: Get your

clients to express themselves freely, *but* you're going to have to warn them that there may be consequences if they obey this injunction. They are instructed on the intricacies of informed consent and the need to fully apprise the client of the limits of confidentiality, but there remains the central dilemma, wherein the very structure of counseling is aimed at encouraging disclosure, even as this disclosure has strings attached. Students trying to find the path through this strenuous middle ground may find themselves to be overtaxed, and as they try to discern their professional responsibility to their future clients, it is no wonder that they seek clear-cut ethical answers (Bowers & Hamlet, 2020).

And it is not only in the legal sense that therapeutic space has been constrained due to the demands of therapeutic responsibility. Counselors and psychotherapists may be responsible for much more than protecting the client from harming themselves or protecting society from harm by their client: they may be responsible for their clients' very souls. London, in a work originally published in 1964 and later updated, suggested that "psychotherapy is a moral force, and psychotherapists, in turn, are moral agents as well as healing technicians" (London, 1986, p. 1). He argued that clinicians couldn't avoid moral problems, such as treating a client who is guilty and anxious over raping or robbing someone at gunpoint—or another client who reports feeling no guilt over committing these crimes. He stated that it is naïve or disingenuous to say that counselors can avoid moral issues, because "the nature of their interactions with patients involves therapists in moral confrontation where moral discourse, even communicating some of their personal morality, may be necessary to their therapeutic work" (p. 10.) He described counselors and psychotherapists as constituting a "secular priesthood" (p. 151), who find justification for their work not in "a theodicy revealed from heaven, but in a code discovered or inspired in clinic, laboratory, and other earthy premises" (p. 153). He suggested that counselors and therapists "fill a moral vacuum in modern life, acting as a third force in an area once dominated by philosophy and religion" (p. 159) who must squarely address "the responsibility of handling moral discourse which they can neither master nor fully dismiss" (p. 160).

London's argument still finds resonance, as it points to crucial unanswerable questions about clinicians' responsibility to address the moral dimensions of behaviors and choices that clients make. How can clinicians address the issues that London raised? Ethical codes may state, for instance, that "counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors" (American Counseling Association, 2014, p. 5), but nowhere is the gulf between ethical aspiration and clinical realization rendered clearer than in this grand pronouncement. It would take a dangerously naïve or disingenuous clinician to believe that not imposing one's beliefs is easy or even perhaps possible in actual work with clients. Too much is expected of the simple word, "impose," as if it were sufficient for the clinician to simply intone, "I shall not impose my views on my client."

With the foregoing in mind, clinicians may be well-advised to pause before assuming additional responsibilities. This point could be seen as germane to an intriguing recent debate about the societal and political responsibilities of mental health professionals. A group of mental health professionals have come together to discuss the mental fitness of Donald Trump and whether he is competent to serve as president, and, if he is not, whether they have a duty to warn the nation. Bandy Lee (2017), a psychiatrist at Yale, has presented this argument in her book, "The Dangerous Case of Donald Trump: 27 Psychiatrists and Mental Health Experts Assess a President." In this book, and at various symposiums, Lee and her colleagues have suggested that mental health professionals have a professional responsibility, arising from their knowledge of aberrant and potentially dangerous patterns of behavior, to warn the public about the dangerous behavior of Trump. This argument is often couched in the language of the "duty to warn" or "duty to protect through warning," discussed previously. To some, it may seem like a duty for the mental health professional, a responsibility to use our mental health knowledge and training to protect the country through warning them about Trump's instability or in the extreme, to advocate his removal through the 25th Amendment. Yet as the articles in our special issue and these concluding remarks suggest, clinicians and those who train them may already have their hands full with enough responsibilities as it is.

Regardless of how unsettled these theoretical arguments remain, clinicians can and must act on the information that clients relate to them and try to find their way to balance the opposing poles of responsibility and freedom. This work can be supremely challenging, since clients bring all manner of material to the unsuspecting counselor, material that is the domain of privacy. At times, however, privacy slides into secrecy, wherein the client murmurs, “psst, listen, I think I might have hurt my child...” or, “I want to die and am going to take my own life...”, followed with, “and by the way, you can’t tell anyone, right?”. Counselors are responsible to maintain privacy but not necessarily the kinds of secrecy that family systems and addictions treatment allude to, secrets that keep families and individuals sick. As seen in the articles in this special issue, responsibility is multifaceted, and begins with appropriate training, even to the point of blocking an applicant or candidate from even entering into this responsibility as counselors. Once in training, these responsibility-takers must learn the role of advocate, both in session and in the broader community. Counselors-in-training must learn the awesome responsibility of discerning when privacy turns to secrecy, and when and how to act.

Once in the profession, counselors are responsible to guide and nurture the therapeutic relationship at the beginning, through informed consent and goal and task alignment (Woodside & Luke, 2018); in the middle through obtaining and acting on client feedback, and at the end, to turn termination into the start of more skillful living. We use terms like termination to indicate the finality of the relationship, to disambiguate the future of the relationship, but in spirit the process is closer to transition or commencement. When handled deftly by the counselor, termination is less about the ending of one relationship, and more about a launching forth into new relationships with one’s self and with others. It also commences a life of living with new thoughts, feeling, and behaviors that lead one into a new experience. In this way, clients are reborn into new awareness and tools for living this new life.

We trust that the articles in this special issue have served as evidence of the central role that responsibility plays in the theory and practice of counseling and psychotherapy. The most obvious evidence for the centrality of the concept comes in the ethical principles and practices found in the various psychotherapeutic disciplines. Responsibility confronts clinicians in each and every clinical encounter as they think about how to answer the following question and how it might open or close therapeutic options for their clients: *Given what I know of this person in front of me and what they have told me and are telling me now, what must I do?*

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